



REFERRAL TO PRIMARY CARE

San Diego County Behavioral Health Services (SDCBHS)



SECTION A. REASON FOR REFERRAL

☐ A) For physical healthcare - SDCBHS will continue to provide specialty mental health services.

☐ B) For total healthcare - SDCBHS no longer providing routine treatment. Available for psychiatric consult.

SECTION B. CLIENT INFORMATION and MENTAL HEALTH INFORMATION

Last Name :

First Name:

Middle Initial:

AKA:

Street Address:

Date of Bir

☐ Male ☒ Female

City, State and ZIP:

Last Psychiatric Hospitalization:

Date: : None: ☐

Telephone #

Current Mental Health Diagnosis:

Current Mental Health Symptoms:

Current Mental Health and Non-Psychiatric Medications and Doses:

Known Physical Health Problems:

PLACE A COPY OF THIS FORM IN THE CLIENT'S MEDICAL RECORD



REFERRAL TO PRIMARY CARE

San Diego County Behavioral Health Services (SDCBHS)



SECTION C. BEHAVIORAL HEALTH PROVIDER INFORMATION

Name, Organization OR Medical Group:

Street Address:

City, State, Zip:

Telephone #

Fax #

SECTION D. BEHAVIORAL HEALTH CONTACTS FOR FURTHER INFORMATION

Psychiatrist:

Phone #

Nurse:

Phone #

Case Manager or Clinician:

Phone #

SECTION E. PRIMARY CARE PROVIDER INFORMATION

Name, Organization OR Medical Group

Street Address

City, State, Zip

Telephone #

Fax #

SECTION F. ACCEPTED FOR TREATMENT OR REFERRED BACK TO SDCBHS

☐ Patient accepted for physical health treatment

☐ Patient accepted for psychotropic medication treatment

☐ Patient not accepted for psychotropic medication treatment and referred back due to:

PLACE A COPY OF THIS FORM IN THE CLIENT'S MEDICAL RECORD

SDCBHS MARCH 2010

COUNTY OF SAN DIEGO

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below.

| | | | |
|---|-----------------|----------------|-----------------|
| | | | DATE: |
| PATIENT/RESIDENT/CLIENT | | | |
| LAST NAME: | | FIRST NAME: | MIDDLE INITIAL: |
| ADDRESS | | CITY/STATE: | ZIP CODE: |
| TELEPHONE NUMBER: | SSN (OPTIONAL): | DATE OF BIRTH: | |
| AKA'S: | | | |
| THE FOLLOWING INDIVIDUAL OR ORGANIZATION IS AUTHORIZED TO MAKE THE DISCLOSURE. | | | |
| LAST NAME OR ENTITY: | | FIRST NAME: | MIDDLE INITIAL: |
| ADDRESS | | CITY/STATE: | ZIP CODE: |
| TELEPHONE NUMBER: | | DATE: | |
| THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION. | | | |
| LAST NAME OR ENTITY: | | FIRST NAME: | MIDDLE INITIAL: |
| ADDRESS | | CITY/STATE: | ZIP CODE: |
| TELEPHONE NUMBER: | | DATE: | |

County of San Diego

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Client: _____

Record Number: _____

Program: _____

TREATMENT DATES:

PURPOSE OF REQUEST:

☐ AT THE REQUEST OF THE INDIVIDUAL.

THE FOLLOWING INFORMATION IS TO BE DISCLOSED: (PLEASE CHECK)

- | | |
|---|---|
| <input type="checkbox"/> History and Physical Examination | <input type="checkbox"/> Physician Orders |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Pharmacy records |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Immunization Records |
| <input type="checkbox"/> Medication Records | <input type="checkbox"/> Nursing Notes |
| <input type="checkbox"/> Interpretation of images: x-rays, sonograms, etc. | <input type="checkbox"/> Billing records |
| <input type="checkbox"/> Laboratory results | <input type="checkbox"/> Drug/Alcohol Rehabilitation Records |
| <input type="checkbox"/> Dental records | <input type="checkbox"/> Complete Record |
| <input type="checkbox"/> Psychiatric records including Consultations | <input type="checkbox"/> Other (<i>Provide description</i>) _____ |
| <input type="checkbox"/> HIV/AIDS blood test results; any/all references to those results | |

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed.

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information

County of San Diego

**AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION**

Client: _____

Record Number: _____

Program: _____

from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section 164.524.

I have the right to receive a copy of this authorization. I would like a copy of this authorization. ☐ Yes ☐ No

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

SIGNATURE:

DATE:

IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP OF INDIVIDUAL:

FOR OFFICE USE

VALIDATE IDENTIFICATION ☐

SIGNATURE OF STAFF PERSON:

DATE:

County of San Diego

**AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION**

Client: _____

Record Number: _____

Program: _____

Appendix B Compliance and Confidentiality

Documentation Standards for Client Records

The documentation standards are described below under key topics related to client care. All standards shall be addressed in the client record; however, there is no requirement that the record have a specific document or section addressing these topics.

A. Assessments

1. The following areas shall be included as appropriate as part of a comprehensive client record.
 - Relevant physical health conditions reported by the client shall be prominently identified and updated as appropriate.
 - Presenting problems and relevant conditions affecting the client's physical health and mental health status shall be documented, for example: living situation, daily activities, and social support.
 - Documentation shall describe client strengths in achieving client plan goals.
 - Special status situations that present a risk to client or others shall be prominently documented and updated as appropriate.
 - Documentation shall include medications that have been prescribed by mental health plan physicians, dosages of each medication, dates of initial prescriptions and refills, and documentation of informed consent for medications.
 - Client self report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities shall be clearly documented.
 - A mental health history shall be documented, including: previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information and relevant results of relevant lab tests and consultation reports.
 - For children and adolescents, pre-natal and perinatal events and complete developmental history shall be documented.
 - Documentation shall include past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed and over-the-counter drugs.
 - A relevant mental status examination shall be documented.
 - A five axis diagnosis from the most current DSM, or a diagnosis from the most current ICD, shall be documented, consistent with the presenting problems, history, mental status evaluation and/or other assessment data.
2. Timeliness/Frequency Standard for Assessment
 - The MHP shall establish standards for timeliness and frequency for the above-mentioned elements.

B. Client Plans

1. Client Plans shall:
 - have specific observable and/or specific quantifiable goals

- identify the proposed type(s) of intervention
- have a proposed duration of intervention(s)
- be signed (or electronic equivalent) by:
 - the person providing the service(s), or
 - a person representing a team or program providing services, or
 - a person representing the MHP providing services
- when the client plan is used to establish that services are provided under the direction of an approved category of staff, and if the above staff are not of the approved category,
 - a physician
 - a licensed/"waivered" psychologist
 - a licensed/registered/waivered social worker
 - a licensed/registered/waivered marriage and family therapist or
 - a registered nurse
- In addition,
 - client plans shall be consistent with the diagnoses, and the focus of intervention shall be consistent with the client plan goals, and there shall be documentation of the client's participation in and agreement with the plan. Examples of documentation include, but are not limited to, reference to the client's participation and agreement in the body of the plan, client signature on the plan, or a description of the client's participation and agreement in progress notes.
 - client signature on the plan shall be used as the means by which the MHP documents the participation of the client
 - when the client is a long term client as defined by the MHP, and
 - the client is receiving more than one type of service from the MHP
 - when the client's signature is required on the client plan and the client refuses or is unavailable for signature, the client plan shall include a written explanation of the refusal or unavailability
 - the MHP shall give a copy of the client plan to the client on request

2. Timeliness/Frequency of Client Plan:

- Shall be updated at least annually.
- The MHP shall establish standards for timeliness and frequency for the individual elements of the client plan described in item 1

C. Progress Notes

1. Items that shall be contained in the client record related to the client's progress in treatment include:

- The client record shall provide timely documentation of relevant aspects of client care
- Mental health staff/practitioners shall use client records to document client encounters, including relevant clinical decisions and interventions

- All entries in the client record shall include the signature of the person providing the service (or electronic equivalent); the person's professional degree, licensure or job title; and the relevant identification number, if applicable
- All entries shall include the date services were provided
- The record shall be legible
- The client record shall document referrals to community resources and other agencies, when appropriate
- The client record shall document follow-up care, or as appropriate, a discharge summary

2. Timeliness/Frequency of Progress Notes:

Progress notes shall be documented at the frequency by type of service indicated below:

a. Every Service Contact

- Mental Health Services
- Medical Support Services
- Crisis Intervention

b. Daily

- Crisis Residential
- Crisis Stabilization (1x/23hr)
- Day Treatment Intensive

c. Weekly

- Day Treatment Intensive: a clinical summary reviewed and signed by a physician, a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person directing the service
- Day Rehabilitation
- Adult Residential

d. Other

- Psychiatrist health facility services: notes on each shift
- Targeted Case Management: every service contact, daily, or weekly summary
- As determined by the MHP for other services

County of San Diego - Health and Human Services Agency

Mental Health Services

WEEKLY WAIT TIMES REPORT

| | |
|-------------------------|--|
| 1. GENERAL INFORMATION: | |
|-------------------------|--|

| | | | |
|-----------------|--|----------------|--------|
| Contractor Name | | Program Type | ADULT |
| Program Name | | Provider Type | COUNTY |
| Contract Number | | Report Period | |
| Sub Unit Number | | Date Submitted | |
| Submitted By | | Contact Phone | |

2. REQUEST FOR SERVICES LOG WITH WAIT TIMES

[illegible]

WEEKLY WAIT TIMES REPORT

| | | | |
|-----------------|--|----------------|--------|
| Contractor Name | | Program Type | ADULT |
| Program Name | | Provider Type | COUNTY |
| Contract Number | | Report Period | |
| Sub Unit Number | | Date Submitted | |
| Submitted By | | Contact Phone | |

FOR OFFICIAL USE ONLY
A.C.1

Request for Services Log

Title 9, Section 1810.405

Contractual Requirements

May use for wait time calculations

| Inquiry date | Name | Indicate Y or N | | | | Referring Party / District | Response Code | Dispo. Code | Appointment Date (reason for no appt. or unusual delays) |
|-----------------|------|-----------------|-------|------|---------------------|----------------------------|---------------|-------------|---|
| | | M/C | ERMHS | MHSA | Healthy Families | | | | |
| | | | | | | | | | |
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Response Codes

E = Emergent - access within 1 hour
C = Crisis - within 24 hours
U = Urgent - access within 72 hours
H = Patient D/C'd from psychiatric hospital (1 week except when urgent & 72 hr rapid assessment needed)
R = Routine - within 5 days
I = Request for Information/referral

Disposition Codes

1) Made appt.
2) Provided client with health insurance referral information
3) Provided client with Healthy Families, Healthy San Diego
or LIHP referral information
4) Referred out for Emergent Services
5) Referred out for Urgent services
6) Referred out for Routine services
7) Referred out for non-Mental Health services
8) No appt or referral made
9) Other

Adult/Older Adult Mental Health Outpatient Clinics Urgent Walk-in Services Schedule and Contact Information

The hours posted below are for urgent walk-in services only at regional clinics which provide psychiatric outpatient services, including medication. The programs serve Medi-Cal beneficiaries and uninsured adults 18 and over. Insured persons are referred to their own providers. Whenever possible, please call in advance to arrange appointment.

This schedule, arranged by Region, provides the Clinics' addresses, contact phone numbers and urgent Walk-in days/hours.

| REGION | CLINIC | DAY AVAILABLE FOR WALK-IN | TIME AVAILABLE FOR WALK-IN | ADDRESS | PHONE NUMBER | COMMENT/NOTES | PROGRAM MANAGER | COUNTY MHS PROGRAM COORDINATOR |
|---------------|--|---------------------------|----------------------------|---|----------------|---|-----------------|---|
| North Central | CRF/Areta Crowell Center | | | 1963 4th Avenue San Diego, CA 92101 | (619) 233-3432 | | | Virginia West, LCSW 619-563-2744 Virginia.West@sdcounty.ca.gov |
| | CRF/Douglas Young BPSR Center | Mon, Tue, Wed & Fri | 9:00AM - 11:00AM | 10717 Camino Ruiz Suite 207 San Diego, CA 92126 | (858) 695-2211 | Up to 2 admissions per shift. | Jennifer Whelan | |
| | | Thur | 12:00PM - 2:00PM | | | | | |
| | North Central MHC | Mon - Fri | 9:00AM - 4:00PM | 1250 Morena Boulevard San Diego, CA 92110 | (619) 692-8750 | Some direct assessments with MD available each week. To have rapid service capability we will not schedule those more than 1 week out. | Carter Gardner | |
| | CRF/Jane Westin WRC | Mon - Fri | 10:00AM - 4:00PM | 1568 6th Avenue San Diego, CA 92101 | (619) 235-2600 | Walk-ins triaged by clinician and then taken in for assessment or referred out if indicated. After BHA and/or med eval, client is referred out to a BPSR clinic for | Colette Lord | |
| | FHCSD/Logan Heights Family Counseling Center | | | 2204 National Ave. San Diego Ca 92113 | (619) 515-2355 | | | |
| | NHA/Project Enable | Mon - Fri | 10:00AM - 2:00PM | 286 Euclid Avenue Suite 102 San Diego, CA 92114 | (619) 266-2111 | Triaged and scheduled for intake accordingly. Triage Coordinator: Christina Forzani, PsyD | Evelina Jaime | |
| Central | Survivors of Torture International Mental Health Services to Victims of Trauma and Torture | | | Confidential Address | (619) 278-2401 | | | |

| REGION | CLINIC | DAY AVAILABLE FOR WALK-IN | TIME AVAILABLE FOR WALK-IN | ADDRESS | PHONE NUMBER | COMMENT/NOTES | PROGRAM MANAGER | COUNTY MHS PROGRAM COORDINATOR |
|--------|--|---------------------------|----------------------------|--|---|--|------------------------|---|
| | UCSD Outpatient (Gifford) | Mon - Fri | 11:00AM - 3:00PM | 140 Arbor Drive San Diego, CA 92103 | (619) 543-6250 | Consumers must be prepared to be at the clinic for a few hours. | Giovanna Zerbi | |
| | UCSD Outpatient Services for Clients with Co-occurring Disorders | | | 140 Arbor Drive San Diego, CA 92103 | (619) 543-6350 | | | |
| | Union of Pan Asian Communities Biospsychosocial and Rehabilitation (BSPR) Center Mid-City Clinic | | | 5348 University Ave, Suite 101 San Diego CA 92105 | (619) 229-2999 | | | |
| | Union of Pan Asian Communities Biospsychosocial and Rehabilitation (BSPR) Center Serra Mesa | | | 8745 Aero Drive #330 San Diego, CA 92123 | (858) 268-4933 | | | |
| | Deaf Community Services (DCS) of San Diego, Inc. - Outpatient Services for Deaf and Hard of Hearing | | | 3930 Fourth Ave. Suite 300 San Diego CA 92103 | (619) 398-2441 {TTY +1 619-398-2440 | | | |
| East | National Center for Deaf Advocacy- San Diego Deaf Mental Health Services | | | 10765 Woodside Ave. Suite B Santee, CA 92071 | (619) 456-9609 Ans.Svc. (858) 410-1067 | | | Tabatha Lang, MFT 619-563-2741 Tabatha.Lang@sdcounty.ca.gov |
| | BPSR Heartland Center | Mon, Wed & Fri | (M) 9-11(W&F) 9am-12pm | 1060 Estes Street El Cajon, CA 92020 | (619) 440-5133 | Triage Coordinator: Danielle Barcello | Yi-Chuan (Cathy) Cheng | |
| | | Tue & Thur | 9:00AM - 4:00PM | | | | | |
| | Chaldean Middle-Eastern Social Services- Behavioral health | | | 436 S. Magnolia Ave, Ste. 201 El Cajon, CA 92020 | (619) 631-7400 | | | |
| | East County MHC | Mon - Thur | 9:00AM - 4:00PM | 1000 Broadway Suite 210 El Cajon, CA 92021 | (619) 401-5500 | For questions/information, contact Frontline Clinician during walk-in times. Hours listed are for walk-in triage. MD available for meds as deemed necessary. | Luz Fernandez | |
| Fri | | 9:00AM - 3:00PM | | | | | | |

| REGION | CLINIC | DAY AVAILABLE FOR WALK-IN | TIME AVAILABLE FOR WALK-IN | ADDRESS | PHONE NUMBER | COMMENT/NOTES | PROGRAM MANAGER | COUNTY MHS PROGRAM COORDINATOR |
|---------------|--|---------------------------|----------------------------|---|----------------|---|----------------------|---|
| South | Maria Sardiñas WRC | Tue & Thur | 9:00AM - 3:00PM | 1465 30th Street, Ste K San Diego, CA 92154 | (619) 428-1000 | Triage Coordinator: Sandra Carranza | Juan Camarena | Tabatha Lang, MFT 619-563-2741 Tabatha.Lang@sdcounty.ca.gov |
| | South Bay Guidance BPSR | Mon, Wed & Fri | 9:00AM - 1:00PM | 835 3rd Avenue Suite C Chula Vista, CA91911 | (619) 427-4661 | Triage Coordinator: Sandra Camargo | Michael Juan | |
| North Coastal | BPSR – Vista | Mon - Fri | 8:30 AM - 4:00PM | 550 W. Vista Way Suite 407 Vista, CA 92083 | (760) 758-1092 | The walk in hours for BPSR Vista Clinic have not changed. They are open, as we have few walk-ins so we triage on the | Kathy Robbins | Anna Palid, LCSW 619-584-5009 Anna.Palid@sdcounty.ca.gov |
| | Exodus Recovery, Inc. Walk In Assess. Center | Mon - Fri | 11:00AM - 6:30PM | 524 W. Vista Way Vista, CA 92083 | (760) 758-1150 | Hours listed are walk-in assessment. Telepsychiatry also available daily noon to 7pm. Average number of clients seen | Cynthia Halpin Brown | |
| | North Coastal MH Clinic | Mon - Fri | 8:30AM - 4:00PM | 1701 Mission Avenue Suite A Oceanside, CA 92054 | (760) 967-4475 | Hours listed are for immediate triage at walk-in. Assessment scheduled as needed. | Payal Beam | |
| North Inland | BPSR Kinesis North | Mon - Fri | 8:00AM - 4:00PM | 474 W. Vermont Avenue Suite 101 Escondido, CA 92025 | (760) 480-2255 | We have 4 hours at Kinesis Escondido location and 2 hours at each satellite clinics. We are establishing days which as of yet have not been set in stone. Hours listed are for walk-in triage. Dr. available for med refill as deemed necessary. | Scott Elizonado | |
| | Exodus Recovery, Include Walk In Assess. Center | Mon - Fri | 11:00AM - 6:30PM | 660 East Grand Avenue Escondido, CA 92025 | (760) 796-7760 | Hours listed are for walk-in assess-ment. Telepsychiatry also available daily noon to 7pm. Average number of clients seen | Cynthia Halpin Brown | |
| | Mental Health Systems, Inc. Fallbrook Satellite Clinic | | | 1328 South Mission Rd. Fallbrook, CA 92028 | (760) 451-4720 | | | |
| | North Inland MH Clinic | Mon - Fri | 8:30AM - 4:00PM | 125 W. Mission Avenue Suite 103 Escondido, CA 92025 | (760) 747-3424 | Walk -in triage. Assessment scheduled as needed. | Linda Richardson | |
| | Mental Health Systems, Inc. Ramona Satellite Clinic | | | 1521 Main St. Ramona, CA 92065 | (760) 736-2429 | | | |

Service Authorization Form
Interpreter Services for Clients – Access and Authorization

Instructions:

1. To request interpreter services, please complete Client Information, Service Information Section A, and Requester Information and fax to selected interpreter service provider.
2. Complete Service Information Section B after services have been provided or canceled and fax to interpreter service provider. For ongoing requests, an authorized County of San Diego representative should verify and submit the form for processing on a weekly basis.
3. Retain original form at program site for record of services provided.

Please “X” the Provider Selected:

- | <u>Service Provider:</u> | <u>Phone:</u> | <u>Fax:</u> | <u>Type of Interpreting:</u> |
|---|----------------------|--------------------|--------------------------------------|
| <input type="checkbox"/> Interpreters Unlimited | (800) 726-9891 | (800) 726-9822 | Oral/ Spoken Language Interpretation |
| <input type="checkbox"/> Deaf Community Services of San Diego, Inc. | (619) 398-2488 | (619) 398-2490 | American Sign Language |
| <input type="checkbox"/> Network Interpreting Services | (800) 284-1043 | (815) 425-9244 | American Sign Language |

Client Information:

The County of San Diego, HHSA has authorized the following interpreting services for:

Please Indicate Name of Client/Participant(s)

(If any participants are under age 18, please indicate age of minor(s): _____).

Language Requested: _____

Nature of Appointment: _____

Service Information:

| Section A: | | | Section B: | | | |
|------------|---------------|-------------|---------------|-------------|--|------------------------------------|
| Date: | Requested: | | Actual: | | Interpreter's Name: (If Services were canceled, please write "Canceled") | Verified By: (Initial and Date) |
| | Start Time | End Time | Start Time | End Time | | |
| | | | | | | |
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Requester Information:

Requester:

- Name: _____
- Phone: _____
- Fax: _____
- E-mail: _____

Agency Name: _____

Program Name and Address: _____

County Department to be Invoiced: _____

Manager/ Designee Approved By:

(Print Name) (Date)

(Signature) (Date)

Service Site: _____

(If different from Program Address)

Site Contact:

- Name: _____
- Phone: _____
- E-mail: _____

NOTE: IT IS A HIPAA VIOLATION TO EMAIL ANY DOCUMENT CONTAINING PROTECTED HEALTH INFORMATION (PHI).

County of San Diego
Health and Human Services Agency (HHSa)

SERVICE AUTHORIZATION FORM INSTRUCTIONS

The purpose of Service Authorization Form is to request authorized scheduled interpreting services with contracted service providers and to verify that authorized scheduled interpreting services were provided **OR** cancelled and when they were cancelled.

The Service Authorization Form must be completed for each individual requiring interpreter services and authorizes services for one or more date(s) at the specified times and at a single location.

The form accompanying these Instructions dated 01/06/10 replaces all Service Authorization Forms previously in use to request interpreter services for clients/family members.

The Service Authorization Form may not be emailed with client information on it. A copy of the form may be provided to the interpreter if requested.

Note that oral interpreter services must be cancelled 24 hours in advance and American Sign Language (ASL) interpreter services must be cancelled 48 hours in advance. Please notify the client/family member of this requirement and ask them to contact your program in a timely manner if they need to cancel an appointment utilizing interpreter services. Services not cancelled timely will be charged to the County.

Instructions for Completing Section A:

- Select the Service Provider to be contacted by placing an “X” next to the Service Provider’s name.
- Circle either “client” or a “family member” to indicate who is receiving the interpreter services.
- Provide the name of the person/participant(s) needing interpreter services and the date(s) the services are required. If the person is under 18 years of age provide the age only, not the date of birth.
- Complete this section by providing the nature of appointment, language requested, requested start time, and end time. Next fill out all of the requestor information including agency name, program name and address, service site of where interpreting shall take place if different than the program address, and obtain approval by a manager or designee. Multiple appointments can be requested as long as they are at the same service site.
- Provide the name of the County department to be invoiced.
- Mental Health programs are required to indicate if the request is from a Children’s program or an Adult program.
- **FAX the Service Authorization Form with Section A completed to the service provider selected to officially request interpreter services.** * The selected service provider will call or email you to verify availability of interpreter staff.

Instructions for Completing Section B:

- If services were provided, state the date, actual start time, actual end time and the name of the interpreter. If services were cancelled, state the date and time the service request was cancelled.
- Provide initials of staff and date that were witness to services to verify information in Section B is accurate.
- **FAX the Service Authorization Form with Section B completed to the selected provider after the services have either been completed or cancelled.** *

It is an expectation that all programs will make every effort to develop bilingual/bicultural staff to reflect the population they serve. In this way, services will be delivered in a culturally competent manner, in the client’s preferred language; and interpreter services will be utilized more efficiently by everyone.

**Please note that some service providers may provide web based requesting services now or in the future. If the SAF is incorporated into their on-line services then the faxing of the form will not be necessary. Please verify this process with your service provider should there be any questions.*

Appendix D Providing Specialty Mental Health Services

SAN DIEGO COUNTY MENTAL HEALTH PLAN
72 – HOUR POST DISCHARGE LOG FOR SPECIALTY MENTAL HEALTH SERVICES

CARE COORDINATOR: _____

MONTH/YEAR: _____

| Client Name | Anasazi # | Admission Facility & Date of Admission | Date Program Learned of Admission | Date of Discharge | Date of Follow-up Appt. | Client Showed (yes or no) |
|-------------|-----------|---|---|----------------------|-------------------------------|---------------------------------|
| | | | | | | |
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**Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health
(Title IX 1830.205)**

- (a) The following medical necessity criteria determines Medi-Cal reimbursement for specialty mental health services that are the responsibility of the MHP under this subchapter, except as specifically provided.
- (b) The beneficiary must meet criteria outlined in (1), (2), and (3) below to be eligible for services:
 - (1) Be diagnosed by the MHP with one of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:
 - (A) Pervasive Developmental Disorders, except Autistic Disorders
 - (B) Disruptive Behavior and Attention Deficit Disorders
 - (C) Feeding and Eating Disorders of Infancy and Early Childhood
 - (D) Elimination Disorders
 - (E) Other Disorders of Infancy, Childhood, or Adolescence
 - (F) Schizophrenia and Other Psychotic Disorders
 - (G) Mood Disorders
 - (H) Anxiety Disorders
 - (I) Somatoform Disorders
 - (J) Factitious Disorders
 - (K) Dissociative Disorders
 - (L) Paraphilias
 - (M) Gender Identity Disorder
 - (N) Eating Disorder
 - (O) Impulse Control Disorders not Elsewhere Classified
 - (P) Adjustment Disorders

- (Q) Personality Disorders, excluding Antisocial Personality Disorder
- (R) Medication-induced Movement Disorders related to other included diagnoses
- (2) Must have at least one of the following impairments as a result of the mental disorder(s) listed in subdivision (1) above:
 - (A) A significant impairment in an important area of life functioning.
 - (B) A probability of significant deterioration in an important area of life functioning.
 - (C) Except as provided in Section 1830.210, a probability a child will not progress developmentally as individually appropriate. For the purpose of this section, a child is a person under the age of 21 years.
- (3) Must meet each of the intervention criteria listed below:
 - (A) The focus of the proposed intervention is to address the condition identified in (2) above.
 - (B) The expectation is that the proposed intervention will:
 - 1. Significantly diminish the impairment, or
 - 2. Prevent significant deterioration in an important area of life function, or
 - 3. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.
 - (C) The condition would not be responsive to physical health care based treatment.
- (c) When the requirements of this section are met, beneficiaries shall receive specialty mental health services for a diagnosis included in subsection (b)(1) even if a diagnosis that is not included in subsection (b)(1) is also present.

California State Penal Institutions

| | |
|---|---|
| Avenal State Prison | Deuel Vocational Institution |
| California Correctional Center | Folsom State Prison |
| California Correctional Institution | High Desert State Prison |
| California Institution for Men | Ironwood State Prison |
| California Institution for Women | Mule Creek State Prison |
| California Medical Facility | North Kern State Prison |
| California Men's Colony | Northern California Women's Facility |
| California Rehabilitation Center | Pelican Bay State Prison |
| California State Prison, Corcoran | Pleasant Valley State Prison |
| California State Prison, Los Angeles County | Richard J. Donovan Correctional Facility at Rock Mountain |
| California State Prison, Sacramento | Salinas Valley State Prison |
| California State Prison, Solano | San Quentin State Prison |
| Calipatria State Prison | Sierra Conservation Center |
| Centinela State Prison | Valley State Prison for Women |
| California Substance Abuse Treatment Facility | Wasco State Prison |
| Central California Women's Facility | |
| Chuckawalla Valley State Prison | |
| Correctional Training Facility | |

**Mental Health Services Administration
Request for Verification of Veterans Eligibility To Counseling and Guidance Services
Confidential Fax Form**

| | |
|--------------------|--|
| Directions: | Section 1: To be completed by client. Section 2: To be completed by clinician and faxed to San Diego County Veterans Service Office Section 3: To be completed by San Diego County Veterans Service Office and faxed to clinician |
|--------------------|--|

| | |
|-------------------|--|
| Section 1: | Client Claiming Veterans Eligibility Complete This Section Only |
|-------------------|--|

I hereby authorize the release of the information below to the County Veterans Service Office and the Veterans Administration for the purposes of identifying or obtaining benefits as a veteran or eligible dependent of a veteran. I also authorize the County Veterans Service Office and the Veterans Administration to release their findings (to be noted on this fax/form).

Signature: _____ Date: _____

| | |
|------------|--|
| Section 2: | Mental Health Provider Complete This Side |
|------------|--|

| | |
|-------------------|--|
| Section 3: | San Diego County Veterans Service Office Complete This Side |
|-------------------|--|

| |
|-----------------------------|
| To: Veterans Service Office |
| Fax: (619) 232-3960 |

From:

County or Contract staff (please print)

| |
|--------------|
| Program name |
|--------------|

Address _____

| | |
|---------|--|
| Address | |
|---------|--|

city/state/zip

Phone: _____

Comments _____

[illegible]

| | |
|------|-------|
| To: | _____ |
| Fax: | _____ |

From:

CVSO Representative (please print) _____

| | |
|---------|--|
| Address | |
|---------|--|

City/State/Zip

Phone: _____

Phone: _____

Client Current Status _____

| | |
|--|---------------------------------|
| | (Check appropriate boxes below) |
|--|---------------------------------|

☐ Client does not have eligibility to veteran's counseling and guidance services. Please assess for _____ mental health services.

| |
|---|
| <input type="checkbox"/> Client has been determined to be eligible to veteran's counseling and guidance services. Please refer client to the Veterans Service Center below: |
|---|

☐ 2790 Truxton Rd
Ste. 130, San Diego CA 92106-6135
(858) 642-1500

☐ 1 Civic Center Drive
Suite 140
San Marcos, CA 92069-2934
(760) 744--6914

Name of Veteran: _____

DOB: _____

SSN: _____

Date of Entry: _____

Date of Discharge: _____

Branch of Service: _____

Military Serial Number: _____

| |
|------------------|
| VA Claim Number: |
|------------------|

County of San Diego
Health and Human Services Agency
Mental Health Services
Request for Verification of
Veterans Eligibility to counseling and Guidance Services
Confidential Fax Form
HHSA: MHS-# 977(11/17/06)

Client:

MR/Client ID #: _____

Program: _____

START PROGRAM TCC & URC RECORD

Facility Name: _____
Client Name: _____

TCC/URC Date: _____
Admit Date: _____

Client attended this meeting? YES ☐ NO ☐ If no, explain: _____

Input from client (regarding treatment requests, suggestions or preference): _____

Progress and status of presenting symptoms (per client report & staff observations): _____

Response to Medications (per client report & staff observation): _____

Input from Other Mental Health Providers (if applicable): _____

Treatment Recommendations (effective interventions, treatment approach, focus of treatment, housing, follow-up treatment, medications...): _____

Change in Diagnostic Impression: ☐ No Change from Dx at Admission ☐ Change Noted Below

Axis I _____

Axis I _____

Axis II _____

Justification: _____

D/C Plans: **D/C Date:** _____ **Is client at risk for readmission?** No ☐ Yes ☐

Housing: _____

Finances: _____

Med Monitoring: _____

Tx: _____

Other: _____

Signatures of staff attendees: _____

DATE OF NEXT REVIEW:

REVIEW DATE: _____

Note Progress (sxs, med. changes, response to meds., extension needed...) _____

Signatures of staff attendees: _____

County of San Diego
Health and Human Services Agency
Mental Health Services

START TCC & URC RECORD (06/2005)

Client: _____

Medical Record No: _____

Program: _____

URC Minutes

Program Name: _____ Date: _____ Meeting Time: _____

Chairperson Name, Signature and Credentials: _____

Signatures of Committee Members (include credentials): _____

| Client Name | Admit Date | Dates Authorized Through | Tentative D/C Date | Comments |
|-------------|------------|--------------------------|--------------------|----------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

NOTE: Requests for extensions and result will be noted in the "Comments" column
START Policy 606 Attachment A

This section to be used by Provider (Physician, Nurse, Therapist, Case Manager)

Provider

Name: _____

Date: _____

Although _____ (client name) has a MORs Rating of ____6, ____7 or ____8 on-going at the County or Contracted Outpatient Program are justified based on:

- ☐ Client has been in Long Term Care, had a psychiatric hospitalization, or was in a crisis residential facility in the last year
- ☐ Client has been a danger to self or others in the last six months
- ☐ Clients impairment is so substantial and persistent that current living situation is in jeopardy or client is currently homeless
- ☐ Clients' behavior interferes with client's ability to get care elsewhere
- ☐ Complex psychiatric medication regimen is very complex

Comments and Treatment Plan:

This section to be used by Program Manager or designee

- ☐ Treatment justification for on-going services is supported.
- ☐ Treatment justification for on-going services not supported. See reverse for utilization management recommendation

Comments:

Signature: _____ Date: _____

Printed Name: _____

County of San Diego
Health and Human Services Agency
Mental Health Services

Utilization Management
Justification for On-going Services

Client: _____

MR/Client ID #: _____

Program: _____

Based on Utilization Management Review the following services are recommended:

_____ Recommended for referral to Primary Care:

- ☐ Stable functioning
- ☐ Low risk of harm
- ☐ High community support or independent
- ☐ High illness management skills
- ☐ Medications within scope of primary care
- ☐ No hospitalizations or Start admissions within last year

Comments and Transition Plan:

_____ Recommended for referral to FFS or FQHC Psychiatry services:

- ☐ Moderate functioning
- ☐ Low risk of harm
- ☐ Moderate community support or independent
- ☐ Moderate illness management skills
- ☐ Complex medications not within scope of primary care
- ☐ No hospitalizations or Start admissions within last six months

Comments and Transition Plan:

County of San Diego
Health and Human Services Agency
Mental Health Services

Utilization Management
Justification for On-going Services

Client: _____

MR/Client ID #: _____

Program: _____

Outpatient Utilization Review Minutes

Program Name: _____ Date: _____

Committee Members, Credentials:

Signatures:

Chairperson, Credentials:

Signature:

| Client Name | Anasazi # | Disposition | | |
|-------------|-----------|---|--|---|
| | | <input type="checkbox"/> Request Approved | <input type="checkbox"/> Request Reduced | <input type="checkbox"/> Request Denied |
| | | <input type="checkbox"/> Request Approved | <input type="checkbox"/> Request Reduced | <input type="checkbox"/> Request Denied |
| | | <input type="checkbox"/> Request Approved | <input type="checkbox"/> Request Reduced | <input type="checkbox"/> Request Denied |
| | | <input type="checkbox"/> Request Approved | <input type="checkbox"/> Request Reduced | <input type="checkbox"/> Request Denied |
| | | <input type="checkbox"/> Request Approved | <input type="checkbox"/> Request Reduced | <input type="checkbox"/> Request Denied |
| | | <input type="checkbox"/> Request Approved | <input type="checkbox"/> Request Reduced | <input type="checkbox"/> Request Denied |
| | | <input type="checkbox"/> Request Approved | <input type="checkbox"/> Request Reduced | <input type="checkbox"/> Request Denied |

Outpatient Utilization Review Minutes
(continued)
Page ____ of ____

Program Name: _____ **Date:** _____

| Client Name | Anasazi # | Disposition | | |
|-------------|-----------|---|--|---|
| | | <input type="checkbox"/> Request Approved | <input type="checkbox"/> Request Reduced | <input type="checkbox"/> Request Denied |
| | | <input type="checkbox"/> Request Approved | <input type="checkbox"/> Request Reduced | <input type="checkbox"/> Request Denied |
| | | <input type="checkbox"/> Request Approved | <input type="checkbox"/> Request Reduced | <input type="checkbox"/> Request Denied |
| | | <input type="checkbox"/> Request Approved | <input type="checkbox"/> Request Reduced | <input type="checkbox"/> Request Denied |
| | | <input type="checkbox"/> Request Approved | <input type="checkbox"/> Request Reduced | <input type="checkbox"/> Request Denied |
| | | <input type="checkbox"/> Request Approved | <input type="checkbox"/> Request Reduced | <input type="checkbox"/> Request Denied |
| | | <input type="checkbox"/> Request Approved | <input type="checkbox"/> Request Reduced | <input type="checkbox"/> Request Denied |
| | | <input type="checkbox"/> Request Approved | <input type="checkbox"/> Request Reduced | <input type="checkbox"/> Request Denied |
| | | <input type="checkbox"/> Request Approved | <input type="checkbox"/> Request Reduced | <input type="checkbox"/> Request Denied |
| | | <input type="checkbox"/> Request Approved | <input type="checkbox"/> Request Reduced | <input type="checkbox"/> Request Denied |
| | | <input type="checkbox"/> Request Approved | <input type="checkbox"/> Request Reduced | <input type="checkbox"/> Request Denied |
| | | <input type="checkbox"/> Request Approved | <input type="checkbox"/> Request Reduced | <input type="checkbox"/> Request Denied |

_____ Preventive (Maintenance)
 _____ Comprehensive (Traditional)
 _____ Intensive
 _____ Older Adult

| | |
|---------------------|--|
| Location of Service | |
| Duration of Service | |
| Service Code | |

| | | |
|---------------------------------|------------------|--------------------------------|
| _____ Assessment Reviewed | _____ No changes | _____ Changes noted/initialled |
| _____ Medical History Reviewed | _____ No changes | _____ Changes noted/initialled |
| _____ CFE Completed or Reviewed | _____ No changes | _____ Changes noted/initialled |

Current Diagnosis: Axis I _____ # _____. _____

Axis II # _____.

_____ Client has a significant impairment in life functioning. **OR:**

_____ Client has a probability of significant deterioration in an important area of functioning

Describe:

AND all three of the following are true:

The focus of the mental health intervention will address the condition described above

_____ It is expected that the client will benefit from interventions listed on the revised or new Client Plan, which has been signed (_____client refused to sign)

_____ The client's impairment would not be responsive to physical healthcare based treatment

AND:

_____ The client meets Service Level of Care Criteria for Case Management Services (Over)

Clinician Name _____

Signature _____

Date _____

The case manager's signature verifies that client meets both Medical Necessity and Service Level of Care Criteria

County of San Diego
Health and Human Services Agency
Mental Health Services
Case Management Services

SIX MONTH REVIEW AND PROGRESS NOTE

Client:

Medical Record #:

Annual Review Date:

HHSA:MHS-

Page 1 of 2

SERVICE LEVEL OF CARE CRITERIA (Must Meet Either A or B)

Rev. 7-14-09 - CC

A.D.10

A. FOR CONTINUING COMPREHENSIVE (TRADITIONAL) CASE MANAGEMENT SERVICES

Treatment history meets ONE of the following criteria

- _____ 10 days or 2 admissions for psychiatric inpatient treatment in the past twelve months
- _____ 28 days or 4 admissions to a crisis house in the past twelve months.
- _____ Discharge from an IMD in the past twelve months
- _____ LPS Conservatorship is in effect - Client is gravely disabled as a result of a mental disorder.

OR: TWO of the following are true regarding client's functioning

- _____ Client is a young adult (18 – 21) transitioning from the Children's System of Care.
- _____ Client is 55 or older and mental illness is exacerbated due to issues of aging or loss of support.
- _____ Client has at least (3) missed mental health appointments, or documentation that medication has not been taken on at least five occasions during the past twelve months, or has had two or more face-to-face encounters with crisis intervention/emergency services personnel; within the past twelve months
- _____ Besides mental health needs, client requires assistance with two or more human service agencies or public systems such as Drug and Alcohol, Vocational Rehabilitation, Criminal Justice, Physical Health Care, and Public Benefits. List the agencies:

- _____ Due to high risk behaviors, client has had one period of homelessness or one or more disruptions to placement or place of treatment in the past two years. List the disruptions

B. FOR CONTINUING CASE MANAGEMENT AT A PREVENTIVE (MAINTENANCE) LEVEL

BOTH of the following are true

1. _____ Client requires ongoing support and assistance from case management to attend psychiatric treatment appointments or obtain and take medications.
2. _____ Despite ongoing attempts by case manager to allow client to manage own funds and complete necessary paperwork to keep benefits in place, over the past twelve months, client has not been able to do so without assistance and there are no other persons available to provide the assistance.

Additional comments:

| | |
|--|---|
| <div>County of San Diego Health and Human Services Agency Mental Health Services Case Management Services</div> <div>SIX MONTH REVIEW PROGRESS NOTE</div> <div>HHSA:MHS-</div> | <div>Client:</div> <div>Medical Record #:</div> <div>Annual Review Date:</div> <div>Page 2 of 2</div> |
|--|---|

Case Management URC Record

Program Name: _____ URC Date: _____

Client Name: _____ Admission Date: _____

Client S#: _____

Primary Diagnostic Impression and Justification on Date of UR:

Axis I or Axis II:

Chart documents Medical Necessity:

_____ Yes _____ No

Comments:

Chart documents Service Necessity:

_____ Yes _____ No

Comments:

Recommended Level of Case Management Services:

Discharge Plan/Other Service Recommendations:

Name of person reviewing chart

Signature

URC Minutes for Case Management

Program Name:

Date of URC:

Committee Members

| Print Name | Signature | Degree/License |
|------------|-----------|----------------|
| Chair: | | |
| | | |
| | | |
| | | |
| | | |
| | | |

List of Charts Reviewed

| Client Name | Admit Date | Date Authorized Through | Continue at Same LOS | Transfer to Preventive LOS | Transfer to Comprehensive LOS | Discharge from Program | Comments |
|-------------|------------|-------------------------|----------------------|----------------------------|-------------------------------|------------------------|----------|
| | | | Y N | Y N | Y N | Y N | |
| | | | Y N | Y N | Y N | Y N | |
| | | | Y N | Y N | Y N | Y N | |
| | | | Y N | Y N | Y N | Y N | |
| | | | Y N | Y N | Y N | Y N | |
| | | | Y N | Y N | Y N | Y N | |
| | | | Y N | Y N | Y N | Y N | |
| | | | Y N | Y N | Y N | Y N | |

Utilization Review Committee

Program: _____ Quarter/Date: _____

Participants: _____

Client Name: _____

Client ID # : _____

Provider/s name/s: _____

MORs History:

| | |
|-------------|-------------|
| Date: _____ | MORs: _____ |
| Date: _____ | MORs: _____ |
| Date: _____ | MORs: _____ |
| Date: _____ | MORs: _____ |
| Date: _____ | MORs: _____ |
| Date: _____ | MORs: _____ |

Root Cause Analysis:

Client Issues: _____

Environmental issues: _____

Clinical issues: _____

Other: _____

Disposition:

Client to continue services: _____

Client to be referred for services: _____

Client to be discharged: _____

Changes in Treatment Plan/Interventions: _____

Client Referred to: _____

Signature of Program Manager or Designee:

UTILIZATION REVIEW REQUEST AND AUTHORIZATION

Outpatient Treatment

Review Date:

| | | |
|---|---|----------|
| Client: | Client #: | Program: |
| Date of Program Admission: Current Service: <input type="checkbox"/> MHS <input type="checkbox"/> MHS-R <input type="checkbox"/> CM <input type="checkbox"/> Meds Current Planned Session Frequency: <input type="checkbox"/> session/s per month for <input type="checkbox"/> Comments: | DSM IV – TR Axis I – Primary: Code: Secondary: Code: Other: Code: Axis II – Code: Axis III – Code: Axis IV - <input type="checkbox"/> Primary Support Group <input type="checkbox"/> Social Environment <input type="checkbox"/> Educational <input type="checkbox"/> Occupational <input type="checkbox"/> Housing <input type="checkbox"/> Economic <input type="checkbox"/> Access to Health Care <input type="checkbox"/> Interaction with the Legal System <input type="checkbox"/> Other psychosocial and Environmental Problems Axis V - (GAF) Current: Highest in last 12 months: | |
| Does youth and/or family request continuation of service? Y <input type="checkbox"/> N <input type="checkbox"/> (Comments): | | |
| Concurrent Interventions: (Please Check off all that apply): <input type="checkbox"/> TBS <input type="checkbox"/> Day Treatment Intensive <input type="checkbox"/> Day Treatment Rehabilitation <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Other Outpatient (Please Specify): | | |
| Hospitalizations: Y <input type="checkbox"/> N <input type="checkbox"/> (If yes please specify how long ago): <input type="checkbox"/> past month <input type="checkbox"/> past 3 months <input type="checkbox"/> past 6 months <input type="checkbox"/> past year <input type="checkbox"/> more than one year | | |

CURRENT CLIENT FUNCTIONING (CFARS Rating):

| 1 No problem | 2 Less than Slight | 3 Slight Problem | 4 Slight to Moderate | 5 Moderate Problem | 6 Moderate to Severe | 7 Severe Problem | 8 Severe to Extreme | 9 Extreme Problem |
|--|--|--|-------------------------|---|---|---|--|----------------------|
| Depression | | | | Anxiety | | | | |
| <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Happy | <input type="checkbox"/> Sleep Problems | | <input type="checkbox"/> Anxious/Tense | | <input type="checkbox"/> Calm | <input type="checkbox"/> Guilt | |
| <input type="checkbox"/> Sad | <input type="checkbox"/> Hopeless | <input type="checkbox"/> Lacks Energy / Interest | | <input type="checkbox"/> Phobic | | <input type="checkbox"/> Worried/ Fearful | <input type="checkbox"/> Anti-Anxiety Meds | |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Anti-Depression Meds | | <input type="checkbox"/> Obsessive/Compulsive | | <input type="checkbox"/> Panic | | |
| Hyper activity | | | | Thought Process | | | | |
| <input type="checkbox"/> Manic | <input type="checkbox"/> Inattentive | <input type="checkbox"/> Agitated | | <input type="checkbox"/> Illogical | <input type="checkbox"/> Delusional | <input type="checkbox"/> Hallucinations | | |
| <input type="checkbox"/> Sleep Deficit | <input type="checkbox"/> Overactive / Hyperactive | <input type="checkbox"/> Mood Swings | | <input type="checkbox"/> Paranoid | <input type="checkbox"/> Ruminative | <input type="checkbox"/> Command Hallucination | | |
| <input type="checkbox"/> Pressured Speech | <input type="checkbox"/> Relaxed | <input type="checkbox"/> Impulsivity | | <input type="checkbox"/> Derailed Thinking | <input type="checkbox"/> Loose Associations | <input type="checkbox"/> Intact | | |
| <input type="checkbox"/> ADHD Meds | <input type="checkbox"/> Anti-Manic Meds | | | <input type="checkbox"/> Oriented | <input type="checkbox"/> Disoriented | <input type="checkbox"/> Anti-Psych Meds | | |
| Cognitive Performance | | | | Medical / Physical | | | | |
| <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Low Self-Awareness | | | <input type="checkbox"/> Acute Illness | <input type="checkbox"/> Hypochondria | <input type="checkbox"/> Good Health | | |
| <input type="checkbox"/> Poor Attention/Concentration | <input type="checkbox"/> Developmental Disability | | | <input type="checkbox"/> CNS Disorder | <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Need Med./Dental Care | | |
| <input type="checkbox"/> Insightful | <input type="checkbox"/> Concrete Thinking | | | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Poor Nutrition | <input type="checkbox"/> Enuretic/ Encopretic | | |
| <input type="checkbox"/> Impaired Judgment | <input type="checkbox"/> Slow Processing | | | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Seizures | <input type="checkbox"/> Stress-Related Illness | | |
| Traumatic Stress | | | | Substance Use | | | | |
| <input type="checkbox"/> Acute | <input type="checkbox"/> Dreams/Nightmares | | | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Drug(s) | <input type="checkbox"/> Dependence | | |
| <input type="checkbox"/> Chronic | <input type="checkbox"/> Detached | | | <input type="checkbox"/> Abuse | <input type="checkbox"/> Over Counter Drugs | <input type="checkbox"/> Cravings/Urges | | |
| <input type="checkbox"/> Avoidance | <input type="checkbox"/> Repression/Amnesia | | | <input type="checkbox"/> DUI | <input type="checkbox"/> Abstinent | <input type="checkbox"/> I.V. Drugs | | |
| <input type="checkbox"/> Upsetting Memories | <input type="checkbox"/> Hyper Vigilance | | | <input type="checkbox"/> Recovery | <input type="checkbox"/> Interfere w/Functioning | <input type="checkbox"/> Med. Control | | |
| Interpersonal Relationships | | | | Behavior in "Home" Setting | | | | |
| <input type="checkbox"/> Problems w/Friends | <input type="checkbox"/> Diff. Estab./ Maintain | | | <input type="checkbox"/> Disregards Rules | <input type="checkbox"/> Defies Authority | | | |
| <input type="checkbox"/> Poor Social Skills | <input type="checkbox"/> Age-Appropriate Group | | | <input type="checkbox"/> Conflict w/Sibling or Peer | <input type="checkbox"/> Conflict w/Parent or Caregiver | | | |
| <input type="checkbox"/> Adequate Social Skills | <input type="checkbox"/> Supportive Relationships | | | <input type="checkbox"/> Conflict w/Relative | <input type="checkbox"/> Respectful | | | |
| <input type="checkbox"/> Overly Shy | | | | <input type="checkbox"/> Responsible | | | | |
| ADL Functioning | | | | Socio-Legal | | | | |
| <input type="checkbox"/> Handicapped | <input type="checkbox"/> Not Age Appropriate In: | | | <input type="checkbox"/> Disregards Rules | <input type="checkbox"/> Offense/Property | <input type="checkbox"/> Offense/Person | | |
| <input type="checkbox"/> Permanent Disability | <input type="checkbox"/> Communication | <input type="checkbox"/> Self Care | | <input type="checkbox"/> Fire Setting | <input type="checkbox"/> Comm. Control/Reentry | <input type="checkbox"/> Pending Charges | | |
| <input type="checkbox"/> No Known Limitations | <input type="checkbox"/> Hygiene | <input type="checkbox"/> Recreation | | <input type="checkbox"/> Dishonest | <input type="checkbox"/> Use/Con Other(s) | <input type="checkbox"/> Incompetent to Proceed | | |
| | <input type="checkbox"/> Mobility | | | <input type="checkbox"/> Detention/ Commitment | <input type="checkbox"/> Street Gang Member | | | |
| Select: <input type="checkbox"/> Work <input type="checkbox"/> School | | | | Danger to Self | | | | |
| <input type="checkbox"/> Absenteeism | <input type="checkbox"/> Poor Performance | <input type="checkbox"/> Regular | | <input type="checkbox"/> Suicidal Ideation | <input type="checkbox"/> Current Plan | <input type="checkbox"/> Recent Attempt | | |
| <input type="checkbox"/> Dropped Out | <input type="checkbox"/> Learning disabilities | <input type="checkbox"/> Seeking | | <input type="checkbox"/> Past Attempt | <input type="checkbox"/> Self-Injury | <input type="checkbox"/> Self-Mutilation | | |
| <input type="checkbox"/> Employed | <input type="checkbox"/> Doesn't Read/Write | <input type="checkbox"/> Tardiness | | <input type="checkbox"/> "Risk-Taking" Behavior | <input type="checkbox"/> Serious Self-Neglect | <input type="checkbox"/> Inability to Care for Self | | |
| <input type="checkbox"/> Defies Authority | <input type="checkbox"/> Not Employed | <input type="checkbox"/> Suspended | | | | | | |
| <input type="checkbox"/> Disruptive | <input type="checkbox"/> Terminated/ Expelled | <input type="checkbox"/> Skips Class | | | | | | |
| Danger to Others | | | | Security/ Management Needs | | | | |
| <input type="checkbox"/> Violent Temper | <input type="checkbox"/> Threatens Others | | | <input type="checkbox"/> Home w/o Supervision | <input type="checkbox"/> Suicide Watch | | | |
| <input type="checkbox"/> Causes Serious Injury | <input type="checkbox"/> Homicidal Ideation | | | <input type="checkbox"/> Behavioral Contract | <input type="checkbox"/> Locked Unit | | | |
| <input type="checkbox"/> Use of Weapons | <input type="checkbox"/> Homicidal Threats | | | <input type="checkbox"/> Protection from Others | <input type="checkbox"/> Seclusion | | | |
| <input type="checkbox"/> Assaultive | <input type="checkbox"/> Homicide Attempt | | | <input type="checkbox"/> Home w/Supervision | <input type="checkbox"/> Run/Escapes Risk | | | |
| <input type="checkbox"/> Cruelty to Animals | <input type="checkbox"/> Accused of Sexual Assault | | | <input type="checkbox"/> Restraint | <input type="checkbox"/> Involuntary Exam/ Commitment | | | |
| <input type="checkbox"/> Does not appear dangerous to Others | <input type="checkbox"/> Physically Aggressive | | | <input type="checkbox"/> Time-Out | <input type="checkbox"/> PRN Medications | | | |
| | | | | <input type="checkbox"/> Monitored House Arrest | <input type="checkbox"/> One-to-One Supervision | | | |

RATIONEL FOR ADDITIONAL SERVICE NEED

County of San Diego – CMHS

Utilization Management Authorization
Form Fill

HHSA:MHS-XXX (2/1/12)

Client:

Client #:

Program:

☐ New Client Plan attached

ELIGIBILITY CRITERIA – POST INITIAL 13 SESSIONS

- ☐ Client continues to meet Medical Necessity and demonstrates benefit from services
☐ Consistent participation in services
☐ CFARS-Impairment Rating guideline of 5

☐ Client meets the criteria for SED based upon the following:

As a result of a mental disorder the child has substantial and persistent impairment in at least two of the following areas (check):

- ☐ Self-care and self regulation
☐ Family relationships
☐ Ability to function in the community
☐ School functioning

AND One of the following occurs:

- ☐ Child at risk for removal from home due to a mental disorder
☐ Child has been removed from home due to a mental disorder
☐ Mental disorder/impairment is severe and has been present for six months, or is highly likely to continue for more than one year without treatment.

OR The child displays:

- ☐ acute psychotic features,
☐ imminent risk for suicide
☐ imminent risk of violence to others due to a mental disorder

ELIGIBILITY CRITERIA – POST 26 SESSIONS (Requires COTR approval)

☐ Client has met the above criteria as indicated AND

Meets a minimum of one continuing current Risk Factor related to child's primary diagnosis:

- ☐ Child has been a danger to self or other in the last two weeks
☐ Child experienced severe physical or sexual abuse or has been exposed to extreme violent behaviors in the home in the last two weeks
☐ Child's behaviors are so substantial and persistent that current living situation is in jeopardy
☐ Child exhibited bizarre behaviors in the last two weeks
☐ Child has experienced trauma within the last two weeks

| Proposed Treatment Modalities | Planned Frequency | Expected Outcome and Prognosis | REQUESTED NUMBER OF TREATMENT SESSIONS |
|--|----------------------|--|--|
| <input type="checkbox"/> MHS – Family | session(s) per month | <input type="checkbox"/> Return to full functioning | <div></div> |
| <input type="checkbox"/> MHS – Group | session(s) per month | <input type="checkbox"/> Expect improvement, anticipate less than full functioning | |
| <input type="checkbox"/> MHS – Individual | session(s) per month | <input type="checkbox"/> Relieve acute symptoms, return to baseline functioning | REQUESTED NUMBER OF MONTHS (for programs under written COTR approval) <div></div> |
| <input type="checkbox"/> MHS – Collateral | session(s) per month | <input type="checkbox"/> Maintain current status/prevent deterioration | |
| <input type="checkbox"/> Case Management/Brokerage | session(s) per month | <input type="checkbox"/> | |
| <input type="checkbox"/> MHS – Rehab | session(s) per month | | |
| <input type="checkbox"/> Medication Support | session(s) per month | | |

Requesting Staff's Name, Credential and Signature: _____

Date: _____

Co- Signature: _____

Date: _____

Approved # of Sessions: _____ ☐ Request Approved ☐ Request Reduced ☐ Request Denied

Comments: _____

Program Level Review: ☐Request Approved ☐Request Reduced ☐Request Denied

Comment: _____

COTR Level Review (past 26 services): ☐Request Approved ☐Request Reduced ☐Request Denied

Attach written COTR response DATE:_____ COTR Name:_____

☐Retroactive Authorization (attach written COTR approval): DATE Approved:_____
Approved Time Frame: _____ COTR Name:_____

UM Clinician's Name: Signature/Credentials: _____ Date:
Committee Members Names and Credentials:

**CMHS OUTPATIENT REDESIGN
BRIEF TREATMENT MODEL
EFFECTIVE 1-1-10
Updated: 2/1/12**

Purpose: Establish session limited brief treatment that is efficient and effective across target populations. Clients shall receive brief treatment services that focus on the one or two most important issues identified by the client/family and conclude when those are stabilized. Clients will be able to obtain services in a timely way and have access back into the system when needed.

Initial Eligibility

Clients that meet the criteria for Title 9 medical necessity shall be eligible for 13 sessions (within a 12 month period).

- 1 Assessment Session
- 12 Treatment Sessions
- Emphasis on group and family treatment
- Adhere to CMHS SED Priority Population – others seen when space permits and priorities as follows:
 - Emergency
 - Urgent
 - ERMHS (Educationally Related Mental Health Services)
 - Routine
- Clients receiving group and/or family sessions only are eligible for an additional five (5) group or family sessions for a total of 18 sessions.
- Applies to MediCal, MHSA (indigent), and Healthy Families SED clients.
- ERMHS clients are subject to ERMHS procedures.
- Included services (count toward 13 sessions): assessment, individual, family and/or group treatment. Individual rehabilitative services are included when provided by a clinician.
- Excluded services (not counted toward 13 sessions): medication management, case management brokerage (CMBR), crisis intervention (CI), plan development, evaluation of records, report preparation, Therapeutic Behavioral Services (TBS), psychological testing (for those programs approved to do testing), and collateral (contact with significant others such as teachers, probation officers, child welfare services workers, and parent/guardians). Paraprofessional rehabilitative services (Rehab-individual, Rehab-group, Rehab-family) are excluded.
- No-show appointments count toward the 13 sessions. Cancelled appointments do not.
- The majority of clients will only be eligible for the initial 13 treatment sessions.
- At the conclusion of the 13 authorized treatment sessions, the client assignment shall be closed unless the client meets SED criteria and reauthorization is obtained.

- Medication-only cases may continue as needed and under existing procedure and are excluded from UM.
- Resuming treatment post medication only phase, resumes the previous UM cycle.
- Evidence Based Programs may be pre-authorized for the program to provide services for the time limited term of the model with written COTR documentation.

Eligibility and Utilization Management: In order to continue services beyond 13 treatment sessions, clients shall meet specific criteria and be reviewed through a Utilization Management process, conducted internally at each program by a licensed clinician.

A. Utilization Management

- Services may continue for one to 13 additional treatment sessions when clinically indicated as determined by UM review.
- The UM process is completed before the end of 13 sessions to determine continued eligibility and services,
- CFARS-Impairment Rating guideline of 5.
- The subsequent 13 treatment sessions must meet all three of the following criteria:
 - 1) Continued Medical Necessity with demonstrated benefit from services
 - 2) Meet SED criteria
 - 3) Consistent participation in services

B. The UM criteria are specifically defined as follows:

- Continue to meet Medical Necessity and demonstrate benefit from services (showing progress).
- Meet SED criteria:
 - 1) As a result of a mental disorder the child has substantial and persistent impairment in at least two of the following areas:
 - a. Self-care and self regulation
 - b. Family relationships
 - c. Ability to function in the community
 - d. School functioning

AND one of the following occurs:

 - e. Child is at risk for removal from home due to a mental disorder.
 - f. Child has been removed from home due to a mental disorder.
 - g. Mental disorder/impairment is severe and has been present for six months, or is highly likely to continue for more than one year without treatment.

OR

 - 2) The child displays: acute psychotic features, is an imminent risk for suicide or imminent risk of violence due to a mental disorder.
- Consistent participation in services as prescribed by treating clinician.

- Current Client Functioning Impairment (CFARS)
Guideline: Rating of 5 (Moderate to Severe) in all domains addressed through the Client Plan as it relates to the client's primary diagnosis.

Post 26 Sessions

- Must obtain prior written COTR approval.
- Approximately 10% of those clients who successfully went through the initial UM will require more than 26 treatment sessions.

To continue beyond 26 treatment sessions clients shall be reviewed through a UM process and meet the following five criteria in order to obtain COTR approval:

- Continued Medical Necessity and demonstrated benefit from services
- Meet SED criteria
- CFARS-Impairment Rating guideline of 5
- Consistent participation in services
- Meet a minimum of one continuing current Risk Factor related to child's primary diagnosis:
 - 1) Child has been a danger to self or other(s) in the last two weeks.
 - 2) Child experienced severe physical or sexual abuse or has been exposed to extreme violent behaviors in the home in the last two weeks.
 - 3) Child's behaviors are so substantial and persistent that the current living situation is in jeopardy.
 - 4) Child exhibited bizarre behaviors in the last two weeks.
 - 5) Child has experienced trauma within the last two weeks. "A trauma is an exceptional experience in which powerful and dangerous events overwhelm the person's capacity to cope."

Utilization Management:

- Clinicians will clearly explain the process and limitations of services to families upon intake. Clients and families will be referred to community services upon discharge if needed.
- UM will be completed at the program level; approval will be by a licensed clinician only. (Post 26 sessions require written authorization from COTR)
- Programs with Family Partners will include the Family Partner as part of the UM review process.
- UM forms will be utilized and will be accompanied by a new Client Plan. Client Plans will be completed within thirty (30) days of admission and prior to UM request.
- CFARS will be completed at admission and discharge and prior to each UM submission (13 sessions, 26 sessions).
- CAMS outcome measures will be administered at intake, aligned with UM cycle and prior to discharge if the previous CAMS is done over 2 months before discharge.

- Providers are required to implement a system to track UM for each client; this may be done at the Anasazi Clinician Home Page.
- Program Managers will report on the Quarterly Status Report (QSR) the number of clients seen at 13, 26, and beyond 26 sessions as it compares to the total number of clients being served.
- Retroactive authorization cannot be obtained at the program level through the the UM process (COTR shall be informed when no UM is in place to determine retroactive authorization).
- Written exception to the UM process by evidence based program may be obtained from COTR.
- Documentation from COTR approving post 26 sessions shall be in medical record and a notation of COTR approval shall be documented on the UM form.
- Client's who seek re-entry post a recently closed assignment (approximately 6 months) shall be evaluated for a new or exacerbated stressor. If client presents a different clinic, previous provider shall be consulted.

INCLUDED AND EXCLUDED SERVICE CODES

Service Codes designated “included” are those that are included when counting the number of sessions provided for the 13 treatment session limit .

| ID | DESCRIPTION | |
|-----------|---------------------------------|----------|
| 5 | SCREENING | excluded |
| 9 | ASSESSMENT PSYCHOSOC INTERACT | included |
| 10 | ASSESSMENT - PSYCHOSOCIAL | included |
| 11 | MEDICATION EVALUATION | excluded |
| 12 | PSYCHOLOGICAL TESTING | excluded |
| 13 | PLAN DEVELOPMENT | excluded |
| 14 | EVAL OF RECORDS FOR ASSESSMENT | excluded |
| 15 | EXTERNAL REPORT PREPARATION | excluded |
| 20 | MEDICATION SUPPORT OTHER | excluded |
| 21 | MEDICATION EDUCATION GROUP | excluded |
| 22 | MEDS - PHARMOCOLOGICAL MGMT | excluded |
| 23 | MED CHECK MD BRIEF | excluded |
| 30 | PSYCHOTHERAPY - INDIVIDUAL | included |
| 31 | PSYCHOTHERAPY - GROUP | included |
| 32 | PSYCHOTHERAPY - FAMILY | included |
| 33 | COLLATERAL | excluded |
| 34 | REHAB – INDIVIDUAL* | excluded |
| 35 | REHAB – GROUP* | excluded |
| 36 | REHAB – FAMILY* | excluded |
| 37 | REHAB EVALUATION | excluded |
| 38 | PSYCHOTHERAPY INTERACTIVE - IND | included |

| | | |
|----|-----------------------------------|----------|
| 39 | PSYCHOTHERAPY INTERACTIVE - GRP | included |
| 40 | COLLATERAL PARENT GROUP | excluded |
| 46 | THERAPEUTIC BEH SVCS - PLAN DEV | excluded |
| 47 | THERAPEUTIC BEH SVCS - DIRECT | excluded |
| 48 | THERAPEUTIC BEH SVCS - ASSESSMENT | excluded |
| 49 | THERAPEUTIC BEH SVCS - COL | excluded |
| 50 | CASE MANAGEMENT/BROKERAGE | excluded |
| 60 | OTHER SUPPORT NON-BILLABLE | excluded |
| 63 | SUBSTANCE ABUSE EDUCATION | excluded |
| 65 | COMMUNITY SERVICES | excluded |
| 70 | CRISIS INTERVENTION | excluded |
| 90 | CRISIS STABILIZATION | excluded |
| 95 | DAY TREATMENT | excluded |

NOTE: rehabilitative services with * are excluded when provided by a paraprofessional and included if provided by a licensed or licensed eligible provider.

ERMHS OUTPATIENT SERVICES REDESIGN

EFFECTIVE 3-1-10

Updated 2/1/12

Purpose: Provide outpatient services that are individualized, strategically planned to maximize efficiency and provide focused delivery of services, and authorized by the client's Individual Education Plan (IEP). These guidelines impact clients who are authorized for outpatient services by the County of San Diego ERMHS Assessors.

Policy

Effective 3/01/10, Special Education Services (SES) staff/assessors when recommending outpatient services will, at the initial IEP, recommend a definitive number of outpatient mental health sessions with a distinct start date and end date that coincide with the annual IEP date. Services may include individual, group and/or family therapy sessions and will be offered for a specific number of sessions until the annual review date. Collateral, case management and medication services, if appropriate, will be offered in addition to the identified treatment sessions.

ERMHS staff shall encourage the utilization of community resources when appropriate, e.g. 12 step groups, NAMI, Families Forward, TBS, as an adjunct to the treatment process.

- The client's IEP with the specific number of outpatient treatment sessions and service period shall act as the authorization document.
- Clinicians and families will need to be strategic in planning how to utilize the allotted sessions.
- The provider's ongoing dialogue with families about focused treatment and realistic expectations of treatment sets the stage for the success of this model.
- The provider's ongoing dialogue with the contact at the client's school is imperative.
- Outpatient providers shall ensure that the client meets medical necessity and must call for an IEP meeting if client is assessed to have different mental health needs than those stipulated on the IEP, recognizing that only SES ERMHS Assessors determine level of care.

The number of outpatient treatment sessions will be identified and authorized based on assessment of need and calculating a certain number of sessions per month. When determining the number of sessions to authorize, attention shall be given to the annual IEP date which is when mental health and the other related services will be reviewed, evaluated and renewed if necessary. Calculations are then based upon the number of months (until the next annual IEP date) rather than a non-specific offer of weekly individual sessions.

Guideline only: To determine the number of sessions to be offered, consideration shall be given to recommending one intake assessment session, and two individual, group or family therapy sessions per month until the annual IEP. In determining the number of sessions to recommend, consideration shall be given to the acuity of the illness during the

assessment process. Some clients may initially need to be seen more often and individually during an acute phase.

Additional Provider Requirements

- Outpatient provider must track the number of included treatment services that have been provided.
- No Shows are considered included services; providers will inform families of this at the onset of treatment.
- The *Client Plan* must integrate/include the IEP mental health goals and identify the number of sessions with start and end dates. The *Client Plan* format (3-1-10) allows for a notation of number of sessions authorized for ERMHS clients.
- Clinicians can “front load” sessions initially by seeing the student or family weekly, and then reducing frequency and referring client to a group for ongoing support as indicated.
- Outcome measures are unchanged. (Youth Satisfaction Surveys annually, CAMS at intake, with the UM/authorization cycle, and at discharge, CFARS on assessment at intake, annually, and at discharge)
- Outpatient providers shall complete *Client Plans* within 30 days of opening of the assignment. The review date for the *Client Plan* shall coincide with the annual IEP date with a client plan requiring annual update per CMHS..

IEP Meeting Preparation and Participation

When a client has four sessions left and additional sessions are needed prior to the annual IEP, provider will contact the designated school personnel for discussion/consultation, and provide the school designee the following two forms:

- 1) *Quarterly Progress Mental Health IEP Report* documenting the client’s progress towards the identified mental health IEP goals. The Quarterly Progress Report requires contact information and notation of the number of outpatient sessions allotted and the number remaining.
- 2) *Need for IEP Review* form indicating that the mental health provider is requesting additional sessions prior to the annual IEP review date.

Additional sessions shall only be requested to ensure continuity of care.

Outpatient providers shall attend IEP meetings and offer clinical recommendations as they relate to mental health services.

- Prior to IEP, provider will have negotiated with the family regarding recommendations.
- Prior to IEP, provider will have communicated with designated school personnel, discussing response to treatment and proposed recommendations for ongoing services.
- At the IEP meeting, provider will clearly state clinical recommendations and if additional mental health service sessions are warranted, identify a reasonable number of sessions to coincide with the next annual IEP date.
- Recommendations shall be individualized with a general guideline of two individual/group/family sessions per month. Groups are a preferred modality

with certain diagnoses and ages, and provide an opportunity for demonstrating progress.

- At the IEP meeting parents will be advised that if they do not attend a session and fail to cancel the session, a “no show” will be counted as part of the total number of services allocated for the client.
- Copy of the current IEP shall be maintained in the client’s medical record.
- The focus of treatment shall be consistent with the agreed upon mental health IEP goals.
- Program staff should regularly coordinate care to update their Demographic Form to reflect current school placement, keeping in mind that Charter Schools and grade level may impact the district of residence.

Annual IEP meetings shall be attended by the whole team, including the mental health clinician. Determination shall be made if services will be terminated or continued based upon the utilization of services, the attainment of the mental health IEP goals, and clinical recommendations.

| | | |
|---|---|--|
| This form should be used to request initial authorization of payment for Day Program services. | County of San Diego Mental Health Plan Initial Day Program Request | fax/mail to: OptumHealth Public Sector, 3111 Camino del Rio North, Suite 500 San Diego, CA 92108 Phone: (800) 798-2254, option #4 Fax: (866) 220-4495 |
| <div style="border: 1px solid black; width: 300px; margin: 0 auto; padding: 5px;"> RECEIVED: </div> | | |
| CLIENT INFORMATION *****CONFIDENTIAL***** | | |
| Client Name: (First & Last) _____ | | Client Anasazi ID#: _____ Date of Birth _____ |
| DAY PROGRAM INFORMATION | | |
| Legal Entity & Day Program Name: <i>Please print clearly</i> _____ | | |
| Phone: _____ | | |
| Day Program Unit# _____ Subunit # _____ Assignment Open Date ____ / ____ / ____ | | |
| Anticipated Date of Discharge ____ / ____ / ____ | | |
| INITIAL AUTHORIZATION REQUEST: <input type="checkbox"/> Intensive Day Treatment <input type="checkbox"/> Day Rehab Frequency : _____ days a week | | |
| Begin Date for this Request: ____ / ____ / ____ End Date for this Request: ____ / ____ / ____ <div style="display: flex; justify-content: space-around;"> mm/dd/yyyy mm/dd/yyyy </div> | | |
| DAY PROGRAM SERVICE NECESSITY CRITERIA COMPLETE DIAGNOSIS and CHECK ALL CRITERIA THAT APPLY | | |
| DIAGNOSIS TIP: Use DSM-IV Codes; include <u>all</u> Axes. Client must also meet Title 9 Medical Necessity Criteria | | |
| Axis I - Primary _____ Axis II - _____ Axis III - _____ Secondary _____ | | |
| Axis IV _____ Axis V (GAF) Current _____ Highest in last 12 months _____ | | |
| For adult clients only: Day Program Services Medical Necessity # _____ (Please review Day Program Medical Necessity Grid to determine this number) | | |
| SERVICE NECESSITY CRITERIA | | |
| 1) Client exhibits an impairment in functioning due to the above diagnosis as evidenced by one or more of the following: | | |
| A. <input type="checkbox"/> Substantial impairment in living arrangement, daily activities, social relationships, and/or age appropriate ADL skills as demonstrated by: (describe) _____ | | |
| B. <input type="checkbox"/> Risk factors such as recurring psychotic symptoms, suicidal or homicidal ideation, without evidence of plan, or other violent ideation or behavior as demonstrated by:(describe) _____ | | |
| C. <input type="checkbox"/> Demonstrative history that without day program services there is a substantial risk of recurrence of A. or B. (describe behavior/history supporting risk.) _____ | | |
| D. <input type="checkbox"/> (For children/youth) Probability that child will not progress developmentally as individually appropriate, or will deteriorate developmentally as demonstrated by: _____ | | |
| 2) <input type="checkbox"/> Client (and family for children) has been in, or is currently in lower level of care and the client has not demonstrated progress or stabilization (describe progress or lack of progress) _____ | | |
| 3) <input type="checkbox"/> Client requires structured Day Program in order to move successfully from higher level of care to lower level of care or to prevent deterioration in functioning and admission to a higher level of care. (describe how is this determined) _____ | | |
| 4) <input type="checkbox"/> Present living situation and functioning indicate need for structured day program. Describe living situation & functioning that supports need for Day Program. _____ | | |
| 5) <input type="checkbox"/> (For children/youth) Recent troubling life events, such as a change of placement, arrest and incarceration, or child abuse. (Describe behaviors/functioning indicating need for Day Program. A formal assessment must confirm medical necessity within 30 days after admission.) _____ | | |

CURRENT FUNCTIONING (CFARS Rating):

| 1 No problem | 2 Less than Slight | 3 Slight Problem | 4 Slight to Moderate | 5 Moderate Problem | 6 Moderate to Severe | 7 Severe Problem | 8 Severe to Extreme | 9 Extreme Problem |
|--|---|--|--------------------------------------|---|-------------------------|--|---|---|
| Depression | | | | Anxiety | | | | |
| <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Happy | <input type="checkbox"/> Sleep Problems | | <input type="checkbox"/> Anxious/Tense | | <input type="checkbox"/> Calm | <input type="checkbox"/> Guilt | |
| <input type="checkbox"/> Sad | <input type="checkbox"/> Hopeless | <input type="checkbox"/> Lacks Energy / Interest | | <input type="checkbox"/> Phobic | | <input type="checkbox"/> Worried/ Fearful | <input type="checkbox"/> Anti-Anxiety Meds | |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Anti-Depression Meds | | <input type="checkbox"/> Obsessive/Compulsive | | <input type="checkbox"/> Panic | | |
| Hyper activity | | | | Thought Process | | | | |
| <input type="checkbox"/> Manic | <input type="checkbox"/> Inattentive | <input type="checkbox"/> Agitated | | <input type="checkbox"/> Illogical | | <input type="checkbox"/> Delusional | <input type="checkbox"/> Hallucinations | |
| <input type="checkbox"/> Sleep Deficit | <input type="checkbox"/> Overactive / Hyperactive | <input type="checkbox"/> Mood Swings | | <input type="checkbox"/> Paranoid | | <input type="checkbox"/> Ruminative | <input type="checkbox"/> Command Hallucination | |
| <input type="checkbox"/> Pressured Speech | <input type="checkbox"/> Relaxed | <input type="checkbox"/> Impulsivity | | <input type="checkbox"/> Derailed Thinking | | <input type="checkbox"/> Loose Associations | <input type="checkbox"/> Intact | |
| <input type="checkbox"/> ADHD Meds | <input type="checkbox"/> Anti-Manic Meds | | | <input type="checkbox"/> Oriented | | <input type="checkbox"/> Disoriented | <input type="checkbox"/> Anti-Psych Meds | |
| Cognitive Performance | | | | Medical / Physical | | | | |
| <input type="checkbox"/> Poor Memory | | <input type="checkbox"/> Low Self-Awareness | | <input type="checkbox"/> Acute Illness | | <input type="checkbox"/> Hypochondria | <input type="checkbox"/> Good Health | |
| <input type="checkbox"/> Poor Attention/Concentration | | <input type="checkbox"/> Developmental Disability | | <input type="checkbox"/> CNS Disorder | | <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Need Med./Dental Care | |
| <input type="checkbox"/> Insightful | | <input type="checkbox"/> Concrete Thinking | | <input type="checkbox"/> Pregnant | | <input type="checkbox"/> Poor Nutrition | <input type="checkbox"/> Enuretic/ Encopretic | |
| <input type="checkbox"/> Impaired Judgment | | <input type="checkbox"/> Slow Processing | | <input type="checkbox"/> Eating Disorder | | <input type="checkbox"/> Seizures | <input type="checkbox"/> Stress-Related Illness | |
| Traumatic Stress | | | | Substance Use | | | | |
| <input type="checkbox"/> Acute | | <input type="checkbox"/> Dreams/Nightmares | | <input type="checkbox"/> Alcohol | | <input type="checkbox"/> Drug(s) | <input type="checkbox"/> Dependence | |
| <input type="checkbox"/> Chronic | | <input type="checkbox"/> Detached | | <input type="checkbox"/> Abuse | | <input type="checkbox"/> Over Counter Drugs | <input type="checkbox"/> Cravings/Urges | |
| <input type="checkbox"/> Avoidance | | <input type="checkbox"/> Repression/Amnesia | | <input type="checkbox"/> DUI | | <input type="checkbox"/> Abstinent | <input type="checkbox"/> I.V . Drugs | |
| <input type="checkbox"/> Upsetting Memories | | <input type="checkbox"/> Hyper Vigilance | | <input type="checkbox"/> Recovery | | <input type="checkbox"/> Interfere w/Functioning | <input type="checkbox"/> Med. Control | |
| Interpersonal Relationships | | | | Behavior in "Home" Setting | | | | |
| <input type="checkbox"/> Problems w/Friends | | <input type="checkbox"/> Diff. Estab./ Maintain | | <input type="checkbox"/> Disregards Rules | | | <input type="checkbox"/> Defies Authority | |
| <input type="checkbox"/> Poor Social Skills | | <input type="checkbox"/> Age-Appropriate Group | | <input type="checkbox"/> Conflict w/Sibling or Peer | | | <input type="checkbox"/> Conflict w/Parent or Caregiver | |
| <input type="checkbox"/> Adequate Social Skills | | <input type="checkbox"/> Supportive Relationships | | <input type="checkbox"/> Conflict w/Relative | | | <input type="checkbox"/> Respectful | |
| <input type="checkbox"/> Overly Shy | | | | <input type="checkbox"/> Responsible | | | | |
| ADL Functioning | | | | Socio-Legal | | | | |
| <input type="checkbox"/> Handicapped | | <input type="checkbox"/> Not Age Appropriate In: | | <input type="checkbox"/> Disregards Rules | | <input type="checkbox"/> Offense/Property | <input type="checkbox"/> Offense/Person | |
| <input type="checkbox"/> Permanent Disability | | <input type="checkbox"/> Communication | <input type="checkbox"/> Self Care | <input type="checkbox"/> Fire Setting | | <input type="checkbox"/> Comm. Control/Reentry | <input type="checkbox"/> Pending Charges | |
| <input type="checkbox"/> No Known Limitations | | <input type="checkbox"/> Hygiene | <input type="checkbox"/> Recreation | <input type="checkbox"/> Dishonest | | <input type="checkbox"/> Use/Con Other(s) | <input type="checkbox"/> Incompetent to Proceed | |
| | | <input type="checkbox"/> Mobility | | <input type="checkbox"/> Detention/ Commitment | | <input type="checkbox"/> Street Gang Member | | |
| Select: <input type="checkbox"/> Work <input type="checkbox"/> School | | | | Danger to Self | | | | |
| <input type="checkbox"/> Absenteeism | | <input type="checkbox"/> Poor Performance | <input type="checkbox"/> Regular | <input type="checkbox"/> Suicidal Ideation | | | <input type="checkbox"/> Current Plan | <input type="checkbox"/> Recent Attempt |
| <input type="checkbox"/> Dropped Out | | <input type="checkbox"/> Learning disabilities | <input type="checkbox"/> Seeking | <input type="checkbox"/> Past Attempt | | | <input type="checkbox"/> Self-Injury | <input type="checkbox"/> Self-Mutilation |
| <input type="checkbox"/> Employed | | <input type="checkbox"/> Doesn't Read/Write | <input type="checkbox"/> Tardiness | <input type="checkbox"/> "Risk-Taking" Behavior | | | <input type="checkbox"/> Serious Self-Neglect | <input type="checkbox"/> Inability to Care for Self |
| <input type="checkbox"/> Defies Authority | | <input type="checkbox"/> Not Employed | <input type="checkbox"/> Suspended | | | | | |
| <input type="checkbox"/> Disruptive | | <input type="checkbox"/> Terminated/ Expelled | <input type="checkbox"/> Skips Class | | | | | |
| Danger to Others | | | | Security/ Management Needs | | | | |
| <input type="checkbox"/> Violent Temper | | <input type="checkbox"/> Threatens Others | | <input type="checkbox"/> Home w/o Supervision | | | <input type="checkbox"/> Suicide Watch | |
| <input type="checkbox"/> Causes Serious Injury | | <input type="checkbox"/> Homicidal Ideation | | <input type="checkbox"/> Behavioral Contract | | | <input type="checkbox"/> Locked Unit | |
| <input type="checkbox"/> Use of Weapons | | <input type="checkbox"/> Homicidal Threats | | <input type="checkbox"/> Protection from Others | | | <input type="checkbox"/> Seclusion | |
| <input type="checkbox"/> Assaultive | | <input type="checkbox"/> Homicide Attempt | | <input type="checkbox"/> Home w/Supervision | | | <input type="checkbox"/> Run/Escape Risk | |
| <input type="checkbox"/> Cruelty to Animals | | <input type="checkbox"/> Accused of Sexual Assault | | <input type="checkbox"/> Restraint | | | <input type="checkbox"/> Involuntary Exam/ Commitment | |
| <input type="checkbox"/> Does not appear dangerous to Others | | <input type="checkbox"/> Physically Aggressive | | <input type="checkbox"/> Time-Out | | | <input type="checkbox"/> PRN Medications | |
| | | | | <input type="checkbox"/> Monitored House Arrest | | | <input type="checkbox"/> One-to-One Supervision | |

CLIENT INFORMATION

****CONFIDENTIAL****

Client Name: (First & Last)

Client Anasazi ID #:

Date of Birth

REQUIRED ATTACHMENTS

PLEASE SUBMIT THE FOLLOWING DOCUMENT WITH THIS INITIAL DAY PROGRAM REQUEST:

☐ Specialty Mental Health Services DPR if the client receives ancillary services in addition to Day Program Services.

Day Program Clinician: (print) _____ Date: _____

Countersignature by Licensed Clinician: _____ Date: _____

For OptumHealth Disposition Only: DOCUMENT AUTHORIZATIONS FOR DAY PROGRAM and ANCILLARY SERVICES

OptumHealth Clinician: _____ Day Program Authorization Period: Begin Date: _____ End Date: _____

Approved # Days: _____ Frequency (# times/week) _____ Review Date: _____ Circle approved AS on next page(s) Logged ☐

Reduce DP Request: ☐ Deny DP Request: ☐ Date NOA Sent: _____ Reduce AS Request: ☐ Deny AS Request: ☐ Date NOA Sent: _____

Date DP Auths Entered: _____ Date AS Auths Entered: _____ D/E Name: _____ Logged ☐

| | | |
|--|--|--|
| <p>This form should be used to request authorization of payment for Specialty Mental Health Services.</p> | <p>County of San Diego Mental Health Plan Specialty Mental Health Services DPR</p> <div data-bbox="535 193 1065 268" style="border: 1px solid black; padding: 10px; margin: 10px auto; width: 350px;"> RECEIVED: </div> | <p>Form must be submitted to OptumHealth Public Sector by client's Day Program provider. OptumHealth Public Sector cannot accept this form if submitted by Specialty Mental Health Services Provider</p> |
| <div> <div>CLIENT INFORMATION</div> <div>****CONFIDENTIAL****</div> </div> | | |
| Client Name: (<i>First & Last</i>) | Client Anasazi ID #: | Date of Birth |
| <div>DAY PROGRAM INFORMATION</div> | | |
| <div> Legal Entity & Day Program Name: <i>Please print clearly</i> <div> <div></div> <div>Phone: : <div></div></div> </div> <div> Day Program Unit# <div></div> Subunit# <div></div> </div> </div> | | |
| <div>SPECIALTY MENTAL HEALTH SERVICES PROGRAM INFORMATION</div> | | |
| <div> Legal Entity & Specialty Mental Health Program Name: <i>Please print clearly</i> <div> <div></div> <div>Phone: : <div></div></div> </div> <div> Specialty Mental Health Program Uni# <div></div> Subunit# <div></div> </div> </div> | | |

CURRENT FUNCTIONING (CFARS Rating) :

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|--|---|--|-------------------------------------|--|---|---|---|---|
| No problem | Less than Slight | Slight Problem | Slight to Moderate | Moderate Problem | Moderate to Severe | Severe Problem | Severe to Extreme | Extreme Problem |
| Depression | | | | | Anxiety | | | |
| <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Happy | <input type="checkbox"/> Sleep Problems | | <input type="checkbox"/> Anxious/Tense | | <input type="checkbox"/> Calm | <input type="checkbox"/> Guilt | |
| <input type="checkbox"/> Sad | <input type="checkbox"/> Hopeless | <input type="checkbox"/> Lacks Energy / Interest | | <input type="checkbox"/> Phobic | | <input type="checkbox"/> Worried/ Fearful | <input type="checkbox"/> Anti-Anxiety Meds | |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Anti-Depression Meds | | <input type="checkbox"/> Obsessive | | <input type="checkbox"/> Panic | | |
| Hyper activity | | | | | Thought Process | | | |
| <input type="checkbox"/> Manic | <input type="checkbox"/> Inattentive | <input type="checkbox"/> Agitated | | <input type="checkbox"/> Illogical | | <input type="checkbox"/> Delusional | <input type="checkbox"/> Hallucinations | |
| <input type="checkbox"/> Sleep Deficit | <input type="checkbox"/> Overactive / Hyperactive | <input type="checkbox"/> Mood Swings | | <input type="checkbox"/> Paranoid | | <input type="checkbox"/> Ruminative | <input type="checkbox"/> Command Hallucinations | |
| <input type="checkbox"/> Pressured Speech | <input type="checkbox"/> Relaxed | <input type="checkbox"/> Impulsivity | | <input type="checkbox"/> Derailed Thinking | | <input type="checkbox"/> Loose Associations | <input type="checkbox"/> Intact | |
| <input type="checkbox"/> ADHD Meds | <input type="checkbox"/> Anti-Manic Meds | | | <input type="checkbox"/> Oriented | | <input type="checkbox"/> Disoriented | <input type="checkbox"/> Anti-Psych Meds | |
| Cognitive Performance | | | | | Medical / Physical | | | |
| <input type="checkbox"/> Poor Memory | | <input type="checkbox"/> Low Self-Awareness | | | <input type="checkbox"/> Acute Illness | | <input type="checkbox"/> Hypochondria | <input type="checkbox"/> Good Health |
| <input type="checkbox"/> Poor Attention/Concentration | | <input type="checkbox"/> Developmental Disability | | | <input type="checkbox"/> CNS Disorder | | <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Need Med./Dental Care |
| <input type="checkbox"/> Insightful | | <input type="checkbox"/> Concrete Thinking | | | <input type="checkbox"/> Pregnant | | <input type="checkbox"/> Poor Nutrition | <input type="checkbox"/> Enuretic/ Encopretic |
| <input type="checkbox"/> Impaired Judgment | | <input type="checkbox"/> Slow Processing | | | <input type="checkbox"/> Eating Disorder | | <input type="checkbox"/> Seizures | <input type="checkbox"/> Stress-Related Illness |
| Traumatic Stress | | | | | Substance Use | | | |
| <input type="checkbox"/> Acute | | <input type="checkbox"/> Dreams/Nightmares | | | <input type="checkbox"/> Alcohol | | <input type="checkbox"/> Drug(s) | <input type="checkbox"/> Dependence |
| <input type="checkbox"/> Chronic | | <input type="checkbox"/> Detached | | | <input type="checkbox"/> Abuse | | <input type="checkbox"/> Over the Counter Drugs | <input type="checkbox"/> Cravings/Urges |
| <input type="checkbox"/> Avoidance | | <input type="checkbox"/> Repression/Amnesia | | | <input type="checkbox"/> DUI | | <input type="checkbox"/> Abstinent | <input type="checkbox"/> I.V . Drugs |
| <input type="checkbox"/> Upsetting Memories | | <input type="checkbox"/> Hyper Vigilance | | | <input type="checkbox"/> Recovery | | <input type="checkbox"/> Interfere w/Functioning | <input type="checkbox"/> Med. Control |
| Interpersonal Relationships | | | | | Behavior in "Home" Setting | | | |
| <input type="checkbox"/> Problems w/Friends | | <input type="checkbox"/> Diff. Estab./ Maintain | | | <input type="checkbox"/> Disregards Rules | | <input type="checkbox"/> Defies Authority | |
| <input type="checkbox"/> Poor Social Skills | | <input type="checkbox"/> Age-Appropriate Group | | | <input type="checkbox"/> Conflict w/Sibling or Peer | | <input type="checkbox"/> Conflict w/Parent or Caregiver | |
| <input type="checkbox"/> Adequate Social Skills | | <input type="checkbox"/> Supportive Relationships | | | <input type="checkbox"/> Conflict w/Relative | | <input type="checkbox"/> Respectful | |
| <input type="checkbox"/> Overly Shy | | | | | <input type="checkbox"/> Responsible | | | |
| ADL Functioning | | | | | Socio-Legal | | | |
| <input type="checkbox"/> Handicapped | | <input type="checkbox"/> Not Age Appropriate In: | | | <input type="checkbox"/> Disregards Rules | | <input type="checkbox"/> Offense/Property | <input type="checkbox"/> Offense/Person |
| <input type="checkbox"/> Permanent Disability | | <input type="checkbox"/> Communication | <input type="checkbox"/> Self Care | | <input type="checkbox"/> Fire Setting | | <input type="checkbox"/> Comm. Control/Reentry | <input type="checkbox"/> Pending Charges |
| <input type="checkbox"/> No Known Limitations | | <input type="checkbox"/> Hygiene | <input type="checkbox"/> Recreation | | <input type="checkbox"/> Dishonest | | <input type="checkbox"/> Use/Con Other(s) | <input type="checkbox"/> Incompetent to Proceed |
| | | <input type="checkbox"/> Mobility | | | <input type="checkbox"/> Detention/ Commitment | | | <input type="checkbox"/> Street Gang Member |
| Select: <input type="checkbox"/> Work <input type="checkbox"/> School | | | | | Danger to Self | | | |
| <input type="checkbox"/> Absenteeism | | <input type="checkbox"/> Poor Performance | | <input type="checkbox"/> Regular | <input type="checkbox"/> Suicidal Ideation | | <input type="checkbox"/> Current Plan | <input type="checkbox"/> Recent Attempt |
| <input type="checkbox"/> Dropped Out | | <input type="checkbox"/> Learning disabilities | | <input type="checkbox"/> Seeking | <input type="checkbox"/> Past Attempt | | <input type="checkbox"/> Self-Injury | <input type="checkbox"/> Self-Mutilation |
| <input type="checkbox"/> Employed | | <input type="checkbox"/> Doesn't Read/Write | | <input type="checkbox"/> Tardiness | <input type="checkbox"/> "Risk-Taking" Behavior | | <input type="checkbox"/> Serious Self-Neglect | <input type="checkbox"/> Inability to Care for Self |
| <input type="checkbox"/> Defies Authority | | <input type="checkbox"/> Not Employed | | <input type="checkbox"/> Suspended | | | | |
| <input type="checkbox"/> Disruptive | | <input type="checkbox"/> Terminated/ Expelled | | <input type="checkbox"/> Skips Class | | | | |
| Danger to Others | | | | | Security/ Management Needs | | | |
| <input type="checkbox"/> Violent Temper | | <input type="checkbox"/> Threatens Others | | | <input type="checkbox"/> Home w/o Supervision | | <input type="checkbox"/> Suicide Watch | |
| <input type="checkbox"/> Causes Serious Injury | | <input type="checkbox"/> Homicidal Ideation | | | <input type="checkbox"/> Behavioral Contract | | <input type="checkbox"/> Locked Unit | |
| <input type="checkbox"/> Use of Weapons | | <input type="checkbox"/> Homicidal Threats | | | <input type="checkbox"/> Protection from Others | | <input type="checkbox"/> Seclusion | |
| <input type="checkbox"/> Assaultive | | <input type="checkbox"/> Homicide Attempt | | | <input type="checkbox"/> Home w/Supervision | | <input type="checkbox"/> Run/Escape Risk | |
| <input type="checkbox"/> Cruelty to Animals | | <input type="checkbox"/> Accused of Sexual Assault | | | <input type="checkbox"/> Restraint | | <input type="checkbox"/> Involuntary Exam/ Commitment | |
| <input type="checkbox"/> Does not appear dangerous to Others | | <input type="checkbox"/> Physically Aggressive | | | <input type="checkbox"/> Time-Out | | <input type="checkbox"/> PRN Medications | |
| | | | | | <input type="checkbox"/> Monitored House Arrest | | <input type="checkbox"/> One-to-One Supervision | |

Clinician requesting authorization: (print) _____ Phone: _____ Date: _____

Countersignature by Licensed Clinician: _____ Phone: _____ Date: _____

| | | |
|---|---|---|
| This form should be used to request <u>continued authorization</u> of payment for Day Program services | County of San Diego Mental Health Plan <u>CONTINUED</u> Day Program Request <div style="border: 1px solid black; height: 30px; margin-top: 10px; text-align: center; padding-top: 5px;">RECEIVED:</div> | Fax/Mail to: OptumHealth Public Sector, 3111 Camino del Rio North, Suite 500 San Diego, CA 92108 Phone: (800) 798-2254, option 4 Fax: (866) 220-4495 |
| CLIENT INFORMATION | | |
| Client Name: <i>(First & Last)</i> _____ | | Client Anasazi ID # _____ |
| Date of Birth _____ | | |
| DAY PROGRAM INFORMATION | | |
| Legal Entity & Day Program Name: <i>Please print clearly</i> _____ Phone: _____ Assignment Open Date _____ Day Program Unit# _____ Subunit# _____ Anticipated Discharge Date: _____ Current Session Frequency : _____ days a week <div style="text-align: center;">mm/dd/yyyy</div> | | |
| CONTINUED AUTHORIZATION REQUEST: <input type="checkbox"/> Intensive Day Treatment <input type="checkbox"/> Day Rehab Frequency : _____ days a week Begin Date for this Request: _____ End Date for this Request: _____ <div style="display: flex; justify-content: space-between;"><div>mm/ dd/ yyyy</div><div>mm/ dd/ yyyy</div></div> | | |
| HISTORY | | |
| <input type="checkbox"/> Significant Life Events Since Last Review : _____ | | |
| DAY PROGRAM SERVICE NECESSITY CRITERIA | | |
| DIAGNOSIS <i>TIP: Use DSM-IV Codes; include <u>all</u> Axes.</i> Client must also meet Title 9 Medical Necessity Criteria Axis I - Primary _____ Axis II - _____ Axis III - _____ Secondary _____ Axis IV _____ Axis V (GAF) Current _____ Highest in last 12 months _____ For adult clients only: Day Program Services Medical Necessity # _____ (Please review Day Program Medical Necessity Grid to determine this number) | | |
| SERVICE NECESSITY CRITERIA | | |
| 1) Client exhibits an impairment in functioning due to the above diagnosis as demonstrated by one or more of the following: A. <input type="checkbox"/> Substantial impairment in living arrangement, daily activities, social relationships, and/or age appropriate ADL skills as demonstrated by: (describe) _____ B. <input type="checkbox"/> Risk factors such as recurring psychotic symptoms, suicidal or homicidal ideation without evidence of plan, or other violent ideation or behavior as demonstrated by: (describe) _____ C. <input type="checkbox"/> Demonstrative history that without day program services there is a substantial risk of recurrence of A. or B. (describe behavior/history supporting risk.) _____ D. <input type="checkbox"/> <i>(For children/youth</i> Probability that child will not progress developmentally as individually appropriate or will deteriorate developmentally as demonstrated by: _____ 2) <input type="checkbox"/> Client (and family for children) has been in, or is currently in lower level of care and the client has not demonstrated progress or stabilization (describe progress or lack of progress) _____ 3) <input type="checkbox"/> Client requires structured Day Program in order to move successfully from higher level of care to lower level of care or to prevent deterioration in functioning and admission to a higher level of care. (describe how is this determined) _____ 4) <input type="checkbox"/> Present living situation and functioning indicate need for structured day program. Describe living situation & functioning that supports need for Day Program. _____ 5) <input type="checkbox"/> Current treatment goals have not been met. There is progress toward treatment goals or a reasonable expectation that progress will be made during the next authorization cycle. _____ | | |

| CLIENT INFORMATION | | |
|-----------------------------|----------------------|----------------|
| ****CONFIDENTIAL**** | | |
| Client Name: (First & Last) | Client Anasazi ID #: | Date of Birth: |

| CLIENT AREAS of STRENGTH | DESCRIBE STRENGTHS IN DETAIL (For children, include family strengths) |
|--|---|
| Job, School, Daily Activities | |
| Relationships, Family, Social Supports | |
| Social Activities, Interests | |

| TREATMENT GOALS: List goals directed at improving functioning. Progress Rating Scale: N – New Goal, 1 – Much worse, 2 – Somewhat worse, 3 – No change, 4 – Slight Improvement, 5 – Great improvement, R – Resolved | | | |
|--|---------------------|------------------------------|----------------------------|
| Measurable Behavioral Goal: | As Demonstrated by: | Method(s) for Achieving Goal | Progress since last report |
| | | | |
| | | | |
| | | | |
| | | | |

| Client received psychiatric evaluation? <input type="checkbox"/> Yes <input type="checkbox"/> No NAME OF PSYCHIATRIST: | | | |
|--|--------------|---------------------|--------------|
| CURRENT MEDICATIONS | Current Dose | CURRENT MEDICATIONS | Current Dose |
| | | | |
| | | | |
| | | | |
| | | | |
| REQUIRED ATTACHMENTS | | | |
| PLEASE SUBMIT THE FOLLOWING DOCUMENT WITH THIS CONTINUING DAY PROGRAM REQUEST: | | | |
| <input type="checkbox"/> Specialty Mental Health Services DPR if the client receives ancillary services in addition to Day Program Services. | | | |

Print Form

Service Authorization Request

For out-of-county organizational providers only.

| | | | | | |
|------------------------------|-------------------|-----------------|----------------------------|-------------|--------------------|
| Client's Name: | | | DOB: | Age: | CIN OR SSN: |
| _____ (First) | _____ (Middle) | _____ (Last) | _____ | _____ | _____ |
| Requesting Agency: | | | Contact Person: | | |
| _____ | | | _____ | | |
| Contact Phone Number: | | | Contact Fax Number: | | |
| _____ | | | _____ | | |
| Submitted to (MHP): | | | Date Submitted: | | |
| _____ | | | _____ | | |

- ☐ Initial Authorization for "Client Assessment" only.
- ☐ Initial Authorization (Required documents: "Client Assessment" and "Client Plan")
- ☐ Re-Authorization (Submit "Client Assessment Update" and "Client Plan" consistent with authorizing MHP's frequency requirements)
- ☐ Annual Re-Authorization (Submit "Client Assessment Update" and "Client Plan" consistent with authorizing MHP's frequency requirements)
- (Please note: The MHP may request clarifying information / documentation to process your request for any of the above)

| Specialty Mental Health Services Requested | Frequency of Service | Total Units Requested | Start Date | End Date | MHP Authorization (initial approved service) |
|---|---|-----------------------|------------|----------|--|
| <input type="checkbox"/> Day Treatment Intensive | _____ Days/week | 3 Months | | | |
| | <input type="radio"/> Half Day <input type="radio"/> Full Day | | | | |
| <input type="checkbox"/> Day Rehabilitation | _____ Days/week | 6 Months | | | |
| | <input type="radio"/> Half Day <input type="radio"/> Full Day | | | | |
| Explain why is this level of service necessary; if requesting more than 5 days per week, include your explanation for this level of care: | | | | | |

Service Necessity:

Child/youth requires a day rehabilitation, a structured program of rehabilitation and therapy, to:

1. ☐ Improve personal independence and functioning.
2. ☐ Maintain personal independence and functioning.
3. ☐ Restore personal independence and functioning.

Child/youth requires day treatment intensive, a structured, multi-disciplinary program program of therapy, which may be:

1. ☐ An alternative to hospitalization.
2. ☐ To avoid placement in a more restrictive environment
3. ☐ To maintain in a community setting.
4. ☐ Other (list): _____

Client Name:

Record/Identification Number:

| Specialty Mental Health Service(s) Requested | Frequency of Service(s) (Indicate how many AND select the Frequency) | Total Minutes Requested | Start Date | End Date | MHP Authorization (initial approved service) |
|--|--|-------------------------|------------|----------|---|
| <input type="checkbox"/> Assessment | _____ per <input type="radio"/> Week <input type="radio"/> Month <input type="radio"/> Authorization | | | | |
| <input type="checkbox"/> Plan Development | _____ per <input type="radio"/> Week <input type="radio"/> Month <input type="radio"/> Authorization | | | | |
| <input type="checkbox"/> Individual Therapy | _____ per <input type="radio"/> Week <input type="radio"/> Month <input type="radio"/> Authorization | | | | |
| <input type="checkbox"/> Group Therapy | _____ per <input type="radio"/> Week <input type="radio"/> Month <input type="radio"/> Authorization | | | | |
| <input type="checkbox"/> Collateral Services | _____ per <input type="radio"/> Week <input type="radio"/> Month <input type="radio"/> Authorization | | | | |
| <input type="checkbox"/> Family Therapy | _____ per <input type="radio"/> Week <input type="radio"/> Month <input type="radio"/> Authorization | | | | |
| <input type="checkbox"/> Targeted Case Mgmt | _____ per <input type="radio"/> Week <input type="radio"/> Month <input type="radio"/> Authorization | | | | |
| <input type="checkbox"/> Medication Support | _____ per <input type="radio"/> Week <input type="radio"/> Month <input type="radio"/> Authorization | | | | |
| <input type="checkbox"/> Other: _____ | _____ per <input type="radio"/> Week <input type="radio"/> Month <input type="radio"/> Authorization | | | | |

Explain why this service level is necessary. If the above services are in addition to day treatment intensive/day rehabilitation services, explain why additional services are needed:

Client Name: _____

Record/Identification Number: _____

| Diagnosis List Primary Diagnosis first. | |
|---|---|
| Axis I: P: _____ _____ _____ Axis II: P: _____ _____ | Axis III: P: _____ _____ Axis IV: P: _____ _____ Axis V: Current GAF: _____ Past Year GAF (if available) _____ |
| Impairment criteria (Must have one of the following impairments as a result of the DSM diagnosis): 1. <input type="checkbox"/> A significant impairment in an important area of life functioning. 2. <input type="checkbox"/> A probability of significant deterioration in an important area of life functioning. 3. <input type="checkbox"/> A probability that the client will not progress developmentally as individually appropriate. 4. <input type="checkbox"/> For EPSDT beneficiaries, a condition as a result of a mental disorder that specialty mental health services can correct or ameliorate. | |
| Intervention criteria (Must have 5, 6, and 7 <u>or</u> 7 and 8): 5. <input type="checkbox"/> The focus of treatment is to address the condition identified in the impairment criteria. 6. <input type="checkbox"/> The proposed intervention will significantly diminish the impairment or prevent significant deterioration in an important area of life functioning or allow the client to progress developmentally as individually appropriate. 7. <input type="checkbox"/> The condition would not be responsive to physical health care based treatment. 8. <input type="checkbox"/> For EPSDT beneficiaries, a condition as a result of a mental disorder that specialty mental health services can correct or ameliorate. | |

Authorized by (Printed Name/License): _____ Date: _____

Signature: _____ Authorizer's Phone Number: _____

Appendix E Interface With Physical Health Care



HEALTHY SAN DIEGO COORDINATION OF CARE FORM GUIDELINES FOR PHYSICAL AND BEHAVIORAL HEALTH PRACTITIONERS

The purpose of the Healthy San Diego (HSD) Coordination of Care form is to provide a communication tool for use between physical and specialty mental health practitioners. Either side of the care continuum may initiate communication by completing the form, obtaining the client's written consent and forwarding the information to the appropriate practitioner. The use of the Coordination of Care form allows for exchange of essential medical information such as diagnosis and medications. By enhancing the communication between practitioners, HSD's goal of improved health outcomes can be achieved.

Primary Care Provider Responsibilities

The Primary Care Provider (PCP) is the primary case manager for the Health Plan member, and as such, makes referrals to specialists, as needed. The PCP is responsible for providing outpatient mental health services within his/her scope of practice. When the member requires Specialty Mental Health Services, the PCP will refer him/her to the Mental Health Plan for appropriate referral, assessment and treatment. The member may also self-refer to the Mental Health Plan's Access and Crisis Line.

- The PCP refers to Specialty Mental Health Services on the basis of objective and subjective evaluation of the member's medical history, psychosocial history, current state of health and any request for such services from either the member or the member's family.
- The PCP will inform the Specialty Mental Health Provider of any physical health conditions or medications which may influence possible mental health conditions.
- The PCP documents the mental health condition in the member's medical record.
- The PCP makes available to the Specialty Mental Health Provider any medical records and documentation relating to the member's mental health condition only if the client signs the Authorization to Release according to Health Plan policy and applicable laws and regulations.

Specialty Mental Health Provider Responsibilities

When a client requires physical health services, the Specialty Mental Health Provider will advise him/her to make an appointment with the PCP or contact the Health Plan's Member Services Department for assistance.

The Specialty Mental Health Provider may make available to the PCP the client's medical information relating to the diagnosis and plan of treatment only if the client signs the Authorization to Release, which allows specific medical information to be given to the PCP. The Specialty Mental Health Provider will inform the Primary Care Provider of any mental health conditions or medications which may influence possible physical health conditions. Mental health information will be shared according to the County Mental Health Plan policy and applicable laws and regulations.

Member/Client Responsibilities

Members/clients can access Specialty Mental Health Services through referrals from their PCP, family members or medical specialists. Clients also may access services directly by calling the County of San Diego Mental Health Plan Access and Crisis Line's toll free number (800) 479-9339 or by contacting a Specialty Mental Health Provider.

HSD's Coordination of Care form is available at www.ubhpublicsector.com

To Reach a Representative

Blue Cross Of California (800) 407-4627
Community Health Group (800) 404-3332

Health Net (800) 675-6110
Kaiser Permanente (800) 464-4000
Sharp Health Plan (800) 359-2002

Universal Care (800) 635-6668
Access and Crisis Line (800) 479-3339



COORDINATION OF PHYSICAL & BEHAVIORAL HEALTH

For Use Between Physical & Behavioral Healthcare Practitioners

SECTION A. CLIENT INFORMATION

| | | | | | |
|-------------------|-------|--------|-----------------------|-------------------------------|---------------------------------|
| CLIENT NAME :LAST | FIRST | MIDDLE | DATE OF BIRTH | <input type="checkbox"/> MALE | <input type="checkbox"/> FEMALE |
| STREET ADDRESS | | | CITY, STATE, ZIP | | |
| TELEPHONE # | | | ALTERNATE TELEPHONE # | | |
| EMERGENCY CONTACT | | | RELATIONSHIP | TELEPHONE # | |

PLEASE ATTACH A SEPERATE PROGRESS NOTE FOR ADDITIONAL SPACE REQUIREMENTS

SECTION B. BEHAVIORAL HEALTH PRACTITIONER INFORMATION

| | | |
|-------------------------------|-----------|------------------------|
| NAME | | |
| ORGANIZATION OR MEDICAL GROUP | | |
| STREET ADDRESS | | CITY, STATE, ZIP |
| TELEPHONE # | | FAX # |
| DATE OF INITIAL ASSESSMENT | DIAGNOSIS | DIAGNOSIS |
| CURRENT SYMPTOMS | | |
| CURRENT MEDICATIONS | | |
| SUMMARY OF PATIENT EVALUATION | | CURRENT TREATMENT PLAN |

SECTION C. PHYSICAL HEALTH PRACTITIONER INFORMATION

| | | |
|-------------------------------|-----------|-------------------------------|
| PRACTITIONER NAME | | ORGANIZATION OR MEDICAL GROUP |
| STREET ADDRESS | | TELEPHONE # |
| CITY, STATE, ZIP | | FAX # |
| DATE OF INITIAL ASSESSMENT | DIAGNOSIS | DIAGNOSIS |
| CURRENT SYMPTOMS | | |
| CURRENT MEDICATIONS | | |
| SUMMARY OF PATIENT EVALUATION | | CURRENT TREATMENT PLAN |

For Use Between Physical & Behavioral Health Practitioners

SENSITIVE INFORMATION: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

PHOTOCOPY OR FAX: I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

REDISCLASURE: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

OTHER RIGHTS: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section 164.524.

SECTION D SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

SIGNATURE:

DATE:

IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP OF INDIVIDUAL:

EXPIRATION: Unless otherwise revoked, this authorization will expire on the following date, event, or condition.

_____-_____-_____. If do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed, or 60 days after termination of treatment.

- | | |
|--|--|
| <input type="checkbox"/> Information Contained on this form | <input type="checkbox"/> Discharge Reports/Summaries |
| <input type="checkbox"/> Current Medication & Treatment Plan | <input type="checkbox"/> Laboratory/Diagnostics Test Results |
| <input type="checkbox"/> Substance Dependence Assessments | <input type="checkbox"/> Medical History |
| <input type="checkbox"/> Assessment /Evaluation Report | <input type="checkbox"/> Other _____ |

Client Name *(Please type or print clearly)*

Last: _____ First: _____ Middle: _____

The above signed authorizes the behavioral health practitioner and the physical health practitioner to release the following medical records and information concerning the patient. The purpose of such a release is to allow for coordination of care, which enhances quality and reduces the risk of duplication of tests and medication interactions. Refusal to provide consent could impair effective coordination of care.

I would like a copy of this authorization ☐ Yes ☐ No Clients Initials _____

ID VALIDATION (For Office Use Only)

SIGNATURE OF STAFF PERSON VALIDATING IDENTIFICATION:

DATE:

SIGNATURE OF HEALTH CARE PROVIDER:

DATE:

PLEASE PLACE A COPY OF THIS FORM IN YOUR CLIENT'S CHART

For Use Between Physical & Behavioral Health Practitioners

Access and Crisis Line's Toll Free number (800) 479-3339

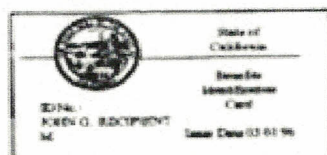


HEALTHY SAN DIEGO

Plan Partner Identification for Pharmacies[†]

Step 1 - State

If patient has this (BIC) CARD:

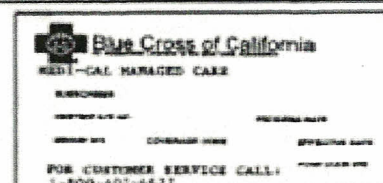


Benefits Identification Card (BIC)

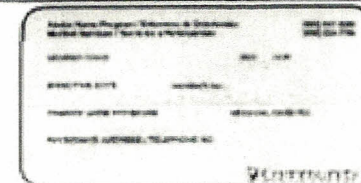
Step 1, please inquire if the patient has one of the other Plan Partner cards.
Step 2, if not, use your Point of Service (POS) Swipe Card Box for Plan Partner, Provider identification, and Member eligibility verification,
or call AEVS at 800-456-2387 or 800-786-4346. Your PIN#

Note: To obtain a POS device, please contact your pharmacy affiliation (Chain, PSAO).

Step 2 - Plan Information



PBM: Wellpoint 800-700-2541
Eligibility: 800-962-7378
Prior Auth. Fax: 888-831-2243
CCU: 800-407-4627
Member ID: Client Identification # (CIN)



PBM: MediImpact: 800-788-2949
Eligibility: 800-854-0208
Prior Auth. Phone: 800-788-2949
Prior Auth. Fax: 800-578-9732
Member ID: Social Security #

Drug Carve-Out List

The drugs listed below should be submitted to Electronic Data System (EDS) Medi-Cal Fee-For-Service (FFS).

HIV/AIDS Drugs:

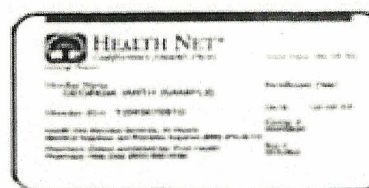
| | | | |
|----------------------|-------------------|---------------------|------------------------|
| Abacavir Sulfate | Emtricitabine | Lopinavir/Ritonavir | Stavudine |
| Amprenavir | Indinavir Sulfate | Nelfinavir Mesylate | Tenofovir Disoproxil |
| Atazanavir | Lamivudine | Nevirapine | Fumarate |
| Delavirdine Mesylate | Lexiva | Ritonavir | Zidovudine/Lamivudine |
| Efavirenz | Lopinavir | Saquinavir | Zidovudine/Lamivudine/ |
| | | Saquinavir Mesylate | Abacavir |

Anti-Psychotic Drugs:

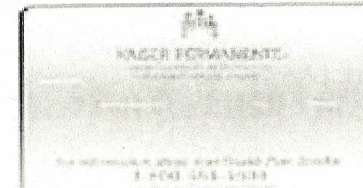
| | | | |
|------------------------|---------------------------|-----------------------|-----------------------|
| Amantadine HCL | Fluphenazine HCL | Mesoridazine Mesylate | Thioridazine HCL |
| Aripiprazole | Haloperidol | Molindone HCL | Thiothixene |
| Benzotropine Mesylate | Haloperidol Decanoate | Olanzapine | Thiothixene HCL |
| * Biperiden HCL | Haloperidol Lactate | Perphenazine | * Tramylcypromine |
| * Biperiden Lactate | * Isocarboxazid | * Phenelzine Sulfate | Sulfate |
| Chlorpromazine HCL | Lithium Carbonate Caps | * Pimozide | Trifluoperazine HCL |
| Chlorprothixene | Lithium Carbonate Tabs/CR | Prochlorperidine HCL | * Trifluoperazine HCL |
| Clozapine | Lithium Citrate Syrup | * Promazine HCL | Trihexyphenidyl |
| Fluphenazine Decanoate | * Loxapine HCL | Quetiapine | Ziprasidone |
| Fluphenazine Enanthate | * Loxapine Succinate | Risperidone | Ziprasidone Mesylate |

* Indicates medications which require a TAR (treatment authorization request)

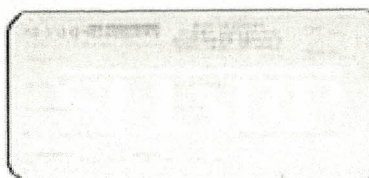
[†] Document adapted courtesy the L.A. Care Health Plan



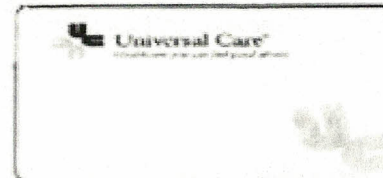
PBM: HNPS
(Health Net Pharmaceutical Services)
Eligibility: 800-554-1444 #1
Prior Auth. Phone: 800-867-6564
Prior Auth. Fax: 800-977-8226
Member ID: Social Security #



PBM: Kaiser Pharmacy Services
Eligibility: 800-464-4000
Medi-Cal Program: 619-528-5282
Member ID: Medical Record #



PBM: RxAmerica 800-770-8014
Eligibility: 800-359-2002
Prior Auth. Phone: 619-228-2400
Prior Auth. Fax: 619-228-2448
Member ID: Social Security #



PBM: MediImpact 800-788-2949
Eligibility: 800-673-4666
Prior Auth. Phone: 800-673-4666
Prior Auth. Fax: 562-981-5808
Member ID: Social Security #

Appendix F Beneficiary Rights Issue Resolution

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

I. BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY

In its commitment to honoring mental health consumer rights, the County of San Diego shall maintain a beneficiary and client problem resolution process, in compliance with State and Federal regulations, which provides a quality, impartial, and effective process for resolving consumer problems encountered while accessing or receiving mental health services. All County-operated and contracted providers shall be required by contract to cooperate with the problem resolution process as described herein. The full and timely cooperation of the provider shall be considered essential in honoring the client's right to an efficient problem resolution.

PLEASE NOTE: PROVIDERS SHALL NOT SUBJECT A CLIENT TO ANY DISCRIMINATION OR ANY OTHER PENALTY OF ANY KIND FOR FILING A GRIEVANCE, APPEAL OR EXPEDITED APPEAL.

A. PROCESS

San Diego County Mental Health Services is committed to providing a quality, impartial, and effective process for resolving consumer complaints encountered while accessing or receiving mental health services. The process is designed to:

- Provide easy access
- Support the rights of individuals
- Be action-oriented
- Provide timely resolution
- Provide effective resolution at the lowest level
- Improve the quality of services for all consumers in the population

While the consumer is encouraged to present problems directly to the provider for resolution, when a satisfactory resolution cannot be achieved, one or more of the processes below may be used:

- 1) Grievance process
- 2) Appeal process (in response to an "action" as defined as: denying or limiting authorization of a requested service, including the type or level or service; reducing, suspending, or terminating a previously authorized service, denying, in whole or in part, payment for a service; failing to provide services in a timely manner, as determined by the Mental Health Plan (MHP) or; failing to act within the timeframes for disposition of standard grievances, the resolution of standard appeals or the resolution of expedited appeals.)

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

- 3) Expedited Appeal process (available in certain limited circumstances)
- 4) State Fair Hearing process--available to Medi-Cal beneficiaries who have filed an appeal through the County Mental Health Program (MHP) process and are dissatisfied with the resolution. The State Fair Hearing is also for clients whose grievance or appeal was not resolved timely in the MHP process (including an extension if permission was given), or no permission for an extension was given. In this instance, clients are not required to wait until the completion of the County MHP process to do so.

The Mental Health Problem Resolution process covers Medi-Cal beneficiaries, Severely Emotionally Disabled (SED) certified children through the Healthy Families program, and persons without Medi-Cal funds receiving County-funded mental health services. It is designed to meet the regulations in CCR Title 9, Division 1, Chapter 11, Subchapter 5, Section 1850.205 and 42 CFR Subpart F, Part 438.400. **The procedures relating to children and youth served under AB 3632/2726 legislation will take precedence over this document.** By law, Welfare and Institution (WI) Code WI 10950, the State Fair Hearing process, is only available to a Medi-Cal beneficiary.

B. OBJECTIVES

1. To provide the consumer with a process for independent resolution of grievances and appeals.
2. To protect the rights of consumers receiving mental health services, including the right to:
 - Be treated with dignity and respect,
 - Be treated with due consideration for his or her privacy,
 - Receive information on available treatment options in a manner appropriate to his or her condition and ability to understand,
 - Participate in decisions regarding his or her mental health care, including the right to refuse treatment,
 - Be free from any form of unnecessary restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation,
 - Request a copy of his or her medical records, and to request that an additional statement amending or correcting the information be included, and
 - Freely exercise these rights without adverse effects in the way providers treat him or her.
3. To protect the rights of consumers during grievance and appeal processes.
4. To assist individuals in accessing medically necessary, high quality, consumer-centered mental health services and education.
5. To respond to consumer concerns in a linguistically appropriate, culturally competent and timely manner.
6. To provide education regarding, and easy access to, the grievance and appeal process through widely available informational brochures, posters, and self-addressed grievance and appeal forms located at all provider sites.

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

C. BENEFICIARY and CLIENT RIGHTS DURING THE GRIEVANCE AND APPEAL PROCESS

1. Consumer concerns shall be responded to in a linguistically appropriate, culturally competent and timely manner.
2. Clients' rights and confidentiality shall be protected at all stages of the grievance and appeal process by all providers and advocates involved.
3. Consumers shall be informed of their right to contact the Jewish Family Service (JFS) Patient Advocacy Program regarding problems at inpatient and residential mental health facilities or the Consumer Center for Health Education and Advocacy (CCHEA) for problems with outpatient and all other mental health services, at any time for assistance in resolving a grievance or appeal. Medi-Cal beneficiaries shall also be informed of their right to request a State Fair Hearing.
4. Consumers of the MHP and persons seeking services shall be informed of the process for resolution of grievances and appeals. This includes information about the availability of the JFS Patient Advocacy Program and CCHEA, the programs that currently are contracted with the MHP to assist consumers with problem resolution, at the consumer's request. The information shall be available in the threshold languages, and shall be given to the client at the point of intake to Mental Health Plan services, and upon request during the provision of services. Continuing clients must be provided with the information annually. Providers shall document the provision of this information.
5. The client may authorize another person or persons to act on his/her behalf. A client may select a provider as his or her representative in the appeal process. His or her representative, or the legal representative of a deceased client's estate, shall be allowed to be included as parties to an appeal.
6. A support person chosen by the client, such as family member, friend or other advocate may accompany them to any meetings or hearings regarding a grievance or appeal.
7. The client and/or his or her representative may examine the case file, including documents or records considered during the grievance or appeal process.
8. Consumers shall not be subject to any discrimination, penalty, sanction or restriction for filing a grievance or appeal. The consumer shall not be discouraged, hindered or otherwise interfered with in seeking or attempting to file a grievance or appeal.
9. Advocates shall treat clients, their chosen support persons, and all providers with courtesy and respect throughout the grievance resolution process.
 - Providers shall participate fully and in a timely manner in order to honor the client's right to an efficient, effective problem resolution process.
 - Medi-Cal beneficiaries, who have appealed through the MHP Beneficiary Problem Resolution process and are dissatisfied with the resolution, have the right to request an impartial review in the form of a State Fair Hearing within 90 days of the decision whether or not the client received a Notice of Action

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(NOA). At a State Fair Hearing, a client has the opportunity to present his or her concerns to an administrative law judge for a ruling. (See Section VIII for more information on the State Fair Hearings.)

- Clients who are Medi-Cal beneficiaries and who have a grievance or appeal which has not been resolved by the MHP within mandated timelines, and no client permission for an extension has been granted, may request a State Fair Hearing. They need not wait until the end of the County process before making the request.
- Quality of care issues identified as a result of the grievance and appeal process shall be reviewed by the MHP and the Quality Review Council for implementation of system changes, as appropriate.

D. CLIENT AND BENEFICIARY NOTIFICATION

1. Consumers shall be informed in a clear and concise way of the process for reporting and resolving grievances and appeals. This includes information on how to contact JFS Patient Advocacy and CCHEA. The information shall be available in the threshold languages and shall be given to the client at the point of intake to a program and, as appropriate, during the provision of services. Continuing clients must be provided with the information annually, and providers will document these efforts.
2. Notices in threshold languages describing mental health rights, as well as the grievance and appeal procedures, shall be posted in prominent locations in public and staff areas, including waiting areas of the provider location. Brochures with this information will also be available in these areas in the County's threshold languages.
3. Grievance/Appeal forms and self-addressed envelopes must be available for consumers at all provider sites in a visible location, without the consumer having to make a written or verbal request to anyone. This includes common areas of both locked and unlocked behavioral health units.
4. CCHEA and Patient Advocacy Program shall have interpreter services and toll-free numbers with adequate TDD/TTY, available at a minimum during normal business hours.
5. Under certain circumstances, when the MHP denies any authorization for payment request from a provider to continue specialty mental health services to a Medi-Cal beneficiary, the MHP must provide the Medi-Cal beneficiary with a Notice of Action (NOA), which informs the beneficiary of his or her right to request a State Fair Hearing, and the right to contact a representative from JFS or CCHEA.

II. INFORMAL PROBLEM RESOLUTION –available to all mental health clients

Consumers are encouraged to seek problem resolution at the provider level by speaking or writing informally to the therapist, case manager, facility staff, or other person

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

involved in their care. Often this is the quickest way to both make the provider aware of the client's issue, as well as come to a satisfactory resolution. **However, no consumer shall be required to take the matter directly to the provider unless he or she chooses.**

In addition to, or instead of, bringing the issue directly to the individual provider, consumers may work directly with the supervisor or Program Director, who shall make efforts to resolve it. In attempting to reach resolution, and consistent with confidentiality requirements, the appropriate supervisor or Program Director shall utilize whatever information, resources and/or contacts the consumer agrees to.

III. GRIEVANCE PROCESS—available to all mental health clients

Any consumer of mental health services may express dissatisfaction with mental health services or their administration by filing a grievance through JFS Patient Advocacy (for inpatient and residential services) or the Consumer Center for Health Education and Advocacy (for outpatient and all other mental health services).

IV. GRIEVANCE PROCEDURES:

At any time the consumer chooses, the consumer may contact CCHEA or JFS Patient Advocacy, as appropriate. CCHEA or JFS Patient Advocacy shall work to resolve the issue according to the following steps:

1. Client contacts JFS Patient Advocacy Program for issues relating to inpatient and other 24-hour-care programs, or CCHEA for issues relating to outpatient, day treatment and all other services, either orally or in writing, to file a grievance. A grievance is defined as an expression of dissatisfaction about anything other than an "action" (see Section IV for complete definition.).

NOTE: If the client's concern is in regard to an "action" as defined, the issue is considered an "appeal" (see Section X for Definition) not a grievance. See "Appeal Process" in Section V below for procedure.

2. CCHEA or Patient Advocacy Program logs the grievance within one working day of receipt. The log shall include:
 - the client name or other identifier,
 - date the grievance was received,
 - the date it was logged, the nature of the grievance,
 - the provider name,
 - whether the issue concerns a child.

The log is to be maintained in a confidential location at CCHEA or JFS Patient Advocacy. The log content pertaining to the client shall be summarized in writing, if the client requests it.

3. CCHEA or Patient Advocacy Program provides the client a written acknowledgement of receipt of the grievance within three working days.
4. CCHEA or Patient Advocacy Program shall contact the provider involved in the grievance as soon as possible and within three working days of receipt of the client's written permission to represent the client.

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5. CCHEA or Patient Advocacy Program investigates the grievance.
 - CCHEA or JFS shall ensure that the person who makes the final determination of the grievance resolution has had no prior or current involvement in the grievance determination.
 - In cases where the CCHEA or JFS staff member has another existing relationship with the client or provider, that contractor's Program Director shall reassign the case or consult with the MHP QI Unit about conflict of interest of issues.
 - The client's confidentiality shall be safeguarded per all applicable laws.
6. If the grievance is about a clinical issue, the decision maker must be a mental health professional with the appropriate clinical expertise in treating the client's condition.
7. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential to honoring the client's right to an efficient, effective problem resolution process. During the resolution of the client's grievance, CCHEA or Patient Advocacy staff will often find it necessary to discuss the issue with the providers involved, either in person or by phone at various points in the process. The expectation is that CCHEA or JFS and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

If a case should arise in which CCHEA or JFS and the provider are unable to reach a mutually agreeable resolution to the grievance within the required timeframe as stated below, CCHEA or JFS shall make a finding based on the facts as they are known. The grievance disposition letter shall include this finding. The letter may include a request that the provider write a Plan of Correction to be submitted by the provider directly to the MHP Director or designee. CCHEA or JFS may also choose to include what they believe to be equitable, enforceable suggestions or recommendations to the provider for resolution of the matter. Notification of the resolution shall go out to all parties as described below.
8. CCHEA or Patient Advocacy Program shall notify the client in writing regarding the disposition of the grievance within the timeframe for resolution stated below. The notice shall include:
 - the date
 - the resolutionA copy of the grievance resolution letter will be sent to the provider and the QI Unit at the time the letter is sent to the client.
9. Timelines for grievance dispositions cannot exceed 60 calendar days from the date of receipt of the grievance. However, in some limited instances, it may be necessary for the timeframe to be extended by up to 14 calendar days for good cause, such as a satisfactory resolution is pending but not complete. Timeliness of grievance resolution is an important issue for consumers. If an extension is required, CCHEA or JFS will contact the client to discuss an extension, clearly

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document in the file the extenuating circumstances that indicate the need for the extension, and the date the client was contacted and agreed to an extension. If the timeframe extension was not requested by the client, CCHEA or JFS staff must give the client written notice of the reason for the delay. If CCHEA or JFS staff is unable to meet the timeframe described herein, the staff person shall issue a Notice of Action D (NOA-D) to the beneficiary informing them of their rights. A copy of the NOA-D shall be sent to the QI Unit. Clients whose grievances are not completed according to mandated timelines, and have not given permission for an extension, may request a State Fair Hearing. They need not wait until the end of the County process to make this request.

10. CCHEA or JFS Patient Advocacy Program shall record in the log, the final disposition of the grievance, and date the decision was sent to the client, or reason there has not been a final disposition of the grievance.
11. Providers who do not successfully resolve the grievance with the advocacy organization during the grievance process shall receive two letters from CCHEA or JFS. One is a copy of the disposition sent to the client, that includes a request for Plan of Correction, and the other is a letter requesting that the provider write a Plan of Correction and submit it within 10 working days directly to:

Grievance Plan of Correction
Quality Improvement Unit
P.O. Box 85524, Mail Stop P531G
Camino Del Rio South
San Diego, CA 92186-5524

The Plan of Correction letter to the provider (not the grievance disposition letter) may include CCHEA's or JFS's suggestions of what the Plan of Correction could include. Responsibility for reviewing the Plan of Correction and monitoring its implementation rests with the MHP. The monitoring of any provider's Plan of Correction and handling of any provider's request for administrative review shall be performed by the MHP directly with the provider.

In the event that a provider disagrees with the findings of the grievance investigation as decided by the advocacy organization, and does not agree to write a Plan of Correction, the provider may choose instead to write a request for administrative review by the MHP. This request shall be submitted directly by the provider to the MHP Director or designee within 10 working days of receipt of the grievance disposition. The provider must include rationale and evidence to support the provider's position that the disposition of the grievance is faulty and/or that no Plan of Correction is indicated.

Reminder: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing a grievance.

GRIEVANCE PROCESS

| STEP | ACTION | TIMELINE |
|------|---------------------------|-------------|
| 1 | Grievance Filed by client | Filing Date |

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| | | |
|---|---|---|
| 2 | Grievance Logged | 1 Working Day from Grievance Filing |
| 3 | Written Acknowledgement to client | 3 Working Days from Grievance Filing |
| 4 | Provider Contact | Within 3 Working Days from Client's Written Permission to Represent |
| 5 | Clinical Consultant review, if applicable | Within 60 day total timeframe |
| 6 | Grievance Disposition | 60 Days from Filing Date |
| 7 | Disposition Extension (if needed) | 14 Calendar Days from the 60 th day |
| 8 | Provider Plan of Correction (if needed) | 10 Working Days from Disposition Date |
| 9 | Request for Administrative Review | 10 Working Days from receipt of the Grievance Disposition |

V. **APPEAL PROCESS—available to Medi-Cal Beneficiaries only**

The appeal procedure begins when a Medi-Cal beneficiary contacts JFS Patient Advocacy Program (for issues relating to inpatient and other 24 hour care program) or CCHEA (for issues relating to outpatient, day treatment and all other services) to file an appeal to review an “action.”

An “action” is defined by 42 Code of Federal Regulations as occurring when the MHP does at least one of the following:

- Denies or limits authorization of a requested service, including the type or level of service;
- Reduces, suspends, or terminates a previously authorized service;
- Denies, in whole or in part, payment for a service;
- Delays completion of the MHP appeals process within the mandated timeframe, without client permission for an extension.

In San Diego County this is relevant only for inpatient, day treatment, and outpatient services provided by fee-for-service providers, as these are currently the only services for which an authorization is required. Clients wishing to have a review of a clinical decision made by an individual provider, not the MHP or its administrative services organization, may use the grievance process.

The MHP is required to provide *Aid Paid Pending* for beneficiaries who want continued services, and have made a timely request for an appeal:

- within 10 days of the date the NOA was mailed, or
- within 10 days of the date the NOA was personally given to the beneficiary, or
- before the effective date of the service change, whichever is later.

The MHP must ensure that benefits are continued while the appeal is pending, if the beneficiary so requests. The beneficiary must have:

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

- an existing service authorization which has not lapsed and the service is being terminated, reduced, or denied for renewal by the MHP, or
- been receiving specialty mental health services under an 'exempt pattern of care' (see Section X. Definitions).

The benefits will stay the same until the period covered by the existing authorization expires, the date an appeal is resolved or a hearing decision is rendered, or the date on which the appeal or state fair hearing is otherwise withdrawn or closed, whichever is earliest.

VI. APPEAL PROCEDURES

1. The client may file the appeal orally or in writing. If the appeal is oral, the client is required to follow up with a signed, written appeal. The client shall be provided with assistance in completing the written appeal, if requested. The date of the oral appeal begins the appeal resolution timeframe, regardless of when the follow-up, written appeal was signed. The client may present evidence in person or in writing.
2. CCHEA or JFS Patient Advocacy Program, as appropriate, determines whether the appeal meets the criteria for expedited appeal and, if so, follows the expedited appeal process as stated in section VI below.
3. CCHEA or Patient Advocacy Program logs the appeal within one working day of receipt. The log shall include the:
 - client name or other identifier,
 - date the appeal was received,
 - date the appeal was logged,
 - nature of the appeal,
 - the provider involved,
 - and whether the issue concerns a child.

The log is to be maintained in a confidential location at CCHEA or JFS Patient Advocacy. If the client requests to see the log, CCHEA or JFS will summarize in writing the content pertaining to the client.

4. CCHEA or JFS shall acknowledge, in writing, receipt of the appeal within three working days.
5. CCHEA or JFS shall contact the provider as soon as possible and within three working days of receipt of the client's written authorization to represent the client.
6. CCHEA or JFS Patient Advocacy Program shall notify the QI Unit within three working days of any appeal filed.
7. CCHEA or JFS evaluates the appeal and:
 - Ensures that the person who determines the final resolution of the appeal has

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

had no decision-making involvement in any prior level of review.

- Safeguards the client's confidentiality per all applicable laws.

In cases where the CCHEA or JFS staff member has another existing relationship with the client or provider, that contractor's Program Director shall reassign the case or consult with the MHP QI Unit about conflict of interest of issues.

8. If the appeal is about a clinical issue, the decision-maker must also be a mental health professional with the appropriate clinical expertise in treating the client's condition.
9. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential in honoring the client's right to an efficient, effective problem resolution process. During the resolution of the client's appeal, CCHEA or JFS staff will often find it necessary to discuss the issue with the providers involved and the Administrative Service Organization (ASO), either in person or by phone at various points in the process. The expectation is that CCHEA or JFS, the ASO, and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

If CCHEA or JFS denies the appeal, or if the appeal is granted but is not an appeal of one of the actions listed in Item #10 below, proceed to item #12.

10. If CCHEA or JFS believes that there is sufficient merit to grant an appeal regarding an action that:
 - denied or limited authorization of a requested service, including the type or level of service,
 - reduced, suspended or terminated a previously authorized service, or
 - denied, in whole or in part, payment for a service, CCHEA or JFS shall do the following within 30 calendar days of the date the appeal was filed:
 - a) notify the MHP Director or designee in writing of details of the appeal and the specific, supported rationale for why it should be granted, and
 - b) provide copies to the MHP Director or designee of all relevant medical records, the clinical consultant's evaluation, case notes, and other materials including an accurate representation of the provider's position regarding the appeal.

In some limited instances, it may be necessary for the timeframe to be extended by up to 14 calendar days for good cause, such as a satisfactory resolution is pending but not complete.

11. The MHP Director or designee shall return a decision on the appeal to the advocacy organization within 10 calendar days of receipt of the above.
12. CCHEA or JFS shall notify the beneficiary in writing regarding the disposition of the appeal within the timeframe for resolution stated below. The notice shall include:

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- the date,
 - the resolution,
 - and if the decision is not wholly in favor of the client AND the client is a Medi-Cal beneficiary, information regarding:
 - the right to request a State Fair Hearing within 90 days of notice of the decision,
 - how to request a State Fair Hearing, and
 - the beneficiary's right to request services while the hearing is pending and how to make that request for continued services.
 - A copy of the appeal resolution letter will be sent to the provider and the Quality Improvement (QI) Unit at the time the letter is sent to the client.
13. Appeals must be resolved within 45 calendar days (59 calendar days if extension granted) from the date of receipt of the appeal. Timeliness of appeal resolution is an important issue for consumers. If an extension is required, CCHEA or Patient Advocacy Program will contact the client to discuss an extension, document clearly in the file the extenuating circumstances for the extension, and the date the client was contacted and agreed to an extension.
 14. If the timeframe extension was not requested by the client, CCHEA or Patient Advocacy staff must give the client written notice of the reason for the delay. The notice shall include the client's right to file a grievance if the client disagrees with the decision to extend the timeframe.
 15. If CCHEA or Patient Advocacy staff is unable to meet the timeframe described herein, they are required to issue an NOA-D to Medi-Cal beneficiaries only. A copy shall be sent to the QI Unit. CCHEA or JFS Patient Advocacy Program shall record in the log the final disposition of the appeal, and the date the decision was sent to the client, or the reason for no final disposition of the appeal.
 16. If the decision of the appeal process reverses a decision to deny services, those services shall be promptly provided.

Reminder: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing an appeal.

APPEALS PROCESS

| STEP | ACTION | TIMELINE |
|------|---|--|
| 1 | Appeal Filed by client | File Date |
| 2 | Appeal Logged | 1 Working Day from Appeal |
| 3 | Expedited Appeal Criteria? | Go to Section VII |
| 4 | Written Acknowledgement of appeal to client | 3 Working Days from Receipt of Appeal |
| 5 | Provider Contact | 3 Working Days from Client's Written Permission to Represent |
| 6 | Clinical consultant review, if applicable | As soon as possible |
| 7 | Notify QI Unit | 3 Working Days of Appeal Filing |
| 8 | Advocacy Organization recommends denying appeal | See #10 for timelines |

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

| | | |
|----|--|--|
| 9 | Advocacy Organization recommends granting the appeal, and notifies MHP Director in writing with supporting documentation | Within 30 calendar days from date appeal was filed |
| 10 | MHP Director makes decision on the appeal | Within 10 calendar days from receipt of appeal. |
| 11 | Appeal Resolution | 45 Calendar Days from Receipt of Appeal |
| 12 | Appeal Extension (if needed) | 14 Calendar Days from Extension Filing Date |

VIII. EXPEDITED APPEAL PROCESS—available to Medi-Cal beneficiaries only

When a client files an oral or written appeal to review an action (as previously defined) and use of the standard appeal resolution process could, in the opinion of the client, the MHP, or CCHEA or JFS Patient Advocacy program staff, jeopardize the client's life, health or ability to attain, maintain, or regain maximum function, the expedited appeal process will be implemented instead.

IX. EXPEDITED APPEAL PROCEDURES

1. The client may file the expedited appeal orally or in writing.
2. The CCHEA or Patient Advocacy Program logs the expedited appeal within one working day of receipt. The log shall include the:
 - client name or other identifier,
 - date appeal was received,
 - date the appeal was logged,
 - nature of the appeal,
 - provider involved,
 - and whether the issue concerns a child.
4. The log is to be maintained in a confidential location at CCHEA or JFS Patient Advocacy. If the client requests to see the log, the advocacy agency will summarize in writing the content pertaining to the client.
5. CCHEA or Patient Advocacy Program provides the client a written acknowledgement of receipt of the expedited appeal within two working days.
6. CCHEA or Patient Advocacy Program shall notify the QI Unit immediately of any expedited appeal filed. CCHEA or Patient Advocacy Program shall contact the provider as soon as possible but not to exceed two working days.
7. The client or his or her representative may present evidence in person or in writing.
8. CCHEA or Patient Advocacy Program evaluates the expedited appeal.
 - They shall ensure that the person who determines the final resolution of the appeal has had no decision-making involvement in any prior level of review.
 - The client's confidentiality shall be safeguarded per all applicable laws.

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9. If the expedited appeal is about a clinical issue, the decision-maker must also be a mental health professional with the appropriate clinical expertise in treating the client's condition.
10. If, CCHEA or Patient Advocacy Program, finds that the appeal does not meet the criteria for the expedited appeal process that has been requested, CCHEA or Patient Advocacy program staff shall:
 - Obtain agreement of the MHP to deny the use of the expedited appeal process and to treat the appeal as a standard appeal instead.
 - Transfer the appeal to the timeframe for standard appeal resolution (above), and
 - Make reasonable efforts to give the client prompt oral notice of the denial of the expedited process, and follow up within two calendar days with a written notice. A copy of the letter shall be sent to QI.
11. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential to honoring the client's right to an efficient, effective problem resolution process. During the resolution of the client's expedited appeal, CCHEA or JFS staff will often find it necessary to discuss the issue with the providers involved, and the Administrative Service Organization (ASO), either in person or by phone at various points in the process. The expectation is that CCHEA or JFS, the ASO, and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

If CCHEA or JFS denies the expedited appeal, or if the expedited appeal is granted but is not an appeal of one of the actions listed in item #12 below, *proceed to item #14.*

12. If the advocacy organization believes that there is sufficient merit to grant an expedited appeal regarding an action that:
 - denied or limited authorization of a requested service, including the type or level of service,
 - reduced, suspended or terminated a previously authorized service, or
 - denied, in whole or in part, payment for a service, the advocacy organization shall do the following within two working days of the date the appeal was filed:
 - notify the MHP Director or designee in writing of details of the expedited appeal and the specific, supported rationale for why it should be granted, and
 - provide copies to the MHP Director or designee of all relevant medical records, the clinical consultant's evaluation, case notes, and other materials including an accurate representation of the provider's position regarding the expedited appeal.
13. The MHP Director or designee shall return a decision on the expedited appeal to the advocacy organization within one working day of receipt of the above.
14. CCHEA or Patient Advocacy Program shall make a reasonable effort to notify the client orally of the expedited appeal resolution decision as soon as possible. In

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addition, they shall notify the client in writing within the timeframe for resolution stated below, regarding the results of the expedited appeal. The notice shall include:

- the date,
- the resolution,
- and only if the decision is not wholly in favor of the client AND the client is a Medi-Cal beneficiary
- information regarding the right to request an expedited State Fair Hearing
- information on how to request continued services (aid paid pending) while the hearing is pending.

A copy of the appeal resolution letter will be sent to the provider and the QI Unit at the same time the letter is sent to the client.

15. Expedited appeals must be resolved and the client must be notified in writing within three working days from the date of receipt of the expedited appeal. However, in some limited instances, it may be necessary for the timeframe to be extended by up to 14 calendar days if the client requests an extension. In rare circumstances, the timeframe may be extended up to the 14 calendar days if CCHEA or JFS staff determines that there is a need for more information AND that the delay is in the client's best interest.
16. If the timeframe extension was not requested by the client, CCHEA or JFS Patient Advocacy staff must give the client written notice of the reason for the delay.
17. If CCHEA or JFS staff is unable to meet the timeframe described herein, they shall issue an NOA-D to the beneficiary. A copy shall be sent to the QI Unit.
18. CCHEA or JFS Patient Advocacy Program shall record in the log the final disposition of the expedited appeal, and the date the decision was sent to the client, or reason there has not been a final disposition of the expedited appeal.
19. If the decision of the appeal process reverses a decision to deny services, those services shall be promptly provided.

Reminder: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing an appeal.

EXPEDITED APPEAL PROCESS

| STEP | ACTION | TIMELINE |
|------|---|--|
| 1 | Expedited Appeal Filed by client | File Date |
| 2 | Expedited Appeal Criteria? If not, obtain MHP agreement and treat as regular appeal. | If no, notify client in 2 calendar days in writing |
| 3 | Expedited Appeal Logged | 1 Working Day from Appeal receipt |
| 4 | Written Acknowledgement of appeal to client | 2 Working Days from Receipt of Appeal |
| 5 | Provider Contact | 2 Working Days from Client's Written Permission to Represent |
| 6 | Notify QI Unit | Immediately |
| 7 | Advocacy Organization recommends denying appeal | See #10 above for timelines |

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| | | |
|----|---|--|
| 8 | Advocacy Organization recommends granting the appeal, and notifies MHP Director in writing with supporting documentation. | Within 2 working days from date appeal was filed |
| 9 | MHP Director makes decision on the appeal | Within 1 working day from receipt of notification from the Advocacy Organization |
| 10 | Appeal Resolution | 3 Working Days from Receipt of Appeal |
| 11 | Disposition Extension (if needed) | 14 Calendar Days from 3 rd working day. |

X. STATE FAIR HEARING—available to Medi-Cal beneficiaries only, who are not receiving services through the Department of Education

A. A State Fair Hearing is a legal process that includes an impartial hearing and ruling by an administrative law judge. A Medi-Cal beneficiary is required to exhaust the MHP's problem resolution process above prior to requesting a State Fair Hearing. Only a Medi-Cal beneficiary may request a state hearing:

- within 90 days after the completion of the MHP beneficiary problem resolution process, whether or not the client received a Notice of Action (NOA), or
- when the grievance or appeal has not been resolved within mandated timelines, and who gave no permission for an extension. The beneficiary does not need to wait for the end of the MHP Problem Resolution process.

A Medi-Cal beneficiary may request a State Fair Hearing by writing to or calling the State Fair Hearings Division of the California Department of Social Services at 1(800) 952-5253, or by contacting CCHEA or JFS Patient Advocacy Program for assistance.

Children and youth receiving mental health services under AB 3632/2726 legislation through the Department of Education should use that Department's Grievance and Appeals process.

B. When the MHP QI Unit has been notified by the State Fair Hearings Division that an appeal or state fair hearing has been scheduled, the QI Unit shall:

1. Contact the client or his or her advocate, investigate the problem, and try to resolve the issue before the matter goes to State Fair Hearing. In cases where a successful resolution of the matter is not reached, the client proceeds to a hearing.
2. Attend the hearing to represent the MHP position.
3. Require that County-operated and/or contracted providers involved in the matter assist in the preparation of a position paper for the hearing, and/or may be requested to attend the hearing as a witness in the case.
4. The MHP is required to provide *Aid Paid Pending* for beneficiaries who want continued services while awaiting a Hearing, have met the Aid Paid Pending criteria per CCR, Title 22, Section 51014.2 summarized below, and have made a timely request for a fair hearing:

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

- within 10 days of the date the NOA was mailed, or
 - within 10 days of the date the NOA was personally given to the beneficiary, or
 - before the effective date of the service change, whichever is later.
- 5. The beneficiary must have:
 - an existing service authorization which has not lapsed and the service is being terminated, reduced, or denied for renewal by the MHP, or
 - been receiving specialty mental health services under an 'exempt pattern of care' (see Section XII. Definitions).
- 6. The benefits will stay the same until the period covered by the existing authorization expires, the date an appeal is resolved or a hearing decision is rendered, or the date on which the appeal or state fair hearing is otherwise withdrawn or closed, whichever is earliest.
- 7. After a judge has heard a case, he or she forwards the decision to the MHP QI Unit. In the event that the case is not resolved in the MHP's favor, the QI Unit staff shall communicate the decision and any actions to be implemented, to the MHP Program Monitors to oversee implementation of the resolution by the County-operated and/or contracted providers.

Please note: A beneficiary may file an appeal or state fair hearing whether or not a Notice of Action (NOA) has been issued.

XI. MONITORING GRIEVANCES AND APPEALS

The MHP QI Unit shall be responsible for monitoring grievances and appeals, identifying issues and making recommendations for needed system improvement.

A. Procedures

1. The MHP QI Unit shall review the files of CCHEA and JFS Patient Advocacy program periodically and as frequently as needed in order to monitor timely adherence to the policy and procedures outlined herein, and ensure that consumer rights under this process are protected to the fullest extent.
2. On a monthly basis, by the 20th of the following month, JFS Patient Advocacy Program and CCHEA shall submit their logs of all grievances and appeals for the previous calendar month, to the MHP QI Unit. The logs shall specify whether each item is a grievance, appeal, or expedited appeal. They shall include the:
 - client name or other identifier
 - date the grievance or appeal was filed,
 - date logged
 - nature of the grievance or appeal
 - provider involved,

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- and whether the issue concerns a child.
- 3. For those grievances and appeals that have been resolved, the log shall note the final disposition of the grievance or appeal, and the date the decision was sent to the client.
- 4. The MHP QI Unit will keep centralized records of monitoring grievances and appeals, including the nature of the grievance/appeal, as well as track outcomes of appeals that were referred to other entities including State Fair Hearings. Trends will be identified and referred to the Quality Review Council, MHP Director, and/or Mental Health Board for recommendations or action as needed. The MHP QI Unit shall submit a grievance and appeal log to the State Department of Mental Health annually.

B. Handling Complaint Clusters

1. CCCHEA and JFS Patient Advocacy shall report to the QI Unit complaint clusters about any one provider or therapist occurring in a period of several weeks or months, immediately upon discovery. Background information and copies of client documentation shall be provided to the QI Unit also.
2. The QI Unit will investigate all such complaint clusters.
3. Findings will be reported to the MHP Director.

XII. DEFINITIONS

ASO: Administrative Service Organization contracted by HHSA to provide Managed Care Administrative functions.

Action: As defined by 42 Code of Federal Regulations (CFR) an action occurs when the Mental Health Plan (MHP) does at least one of the following:

- Denies or limits authorization of a requested service, including the type or level of service;
- Reduces, suspends, or terminates a previously authorized service;
- Denies, in whole or in part, payment for a service;
- Fails to provide services in a timely manner, as determined by the MHP or;
- Fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

| | |
|---|---|
| Appeal: | A request for review of an action (as action is defined above). |
| Beneficiary: | A client who is Medi-Cal eligible and currently requesting or receiving specialty mental health services paid for under the County's Medi-Cal Managed Care Plan. |
| Client: | Any individual currently receiving mental health services from the County MHS system, regardless of funding source. |
| Consumer Center for Health Education and Advocacy (CCHEA): | CCHEA is an MHP contractor currently designated by the Local Mental Health Director to fulfill two roles: to operate the County's Grievance and Appeal process for client problems with outpatient and all other non-residential mental health services; and to provide patient advocacy services which include information and education on client rights and individual assistance for mental health clients with problems accessing/maintaining services in the community. |
| Consumer: | Any individual who is currently requesting or receiving specialty mental health services, regardless of the individual's funding source and/or has received such services in the past and/or the persons authorized to act on his/her behalf. (This includes family members and any other person(s) designated by the client as his/her support system.) |
| Grievance: | An expression of dissatisfaction about any matter other than an action (as action is defined). |
| Grievance and Appeal Process: | A process for the purpose of attempting to resolve consumer problems regarding specialty mental health services. |
| Mental Health Plan (MHP): | County of San Diego, Health & Human Services Agency, Mental Health Services. |

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

Notice of Action (NOA):

A notice sent to Medi-Cal beneficiaries to inform them of a decision regarding denial, reduction, or termination of requested services and their rights for appeal if they disagree with the decision.

NOA-A: (Assessment) Denial of service sent from providers to Medi-Cal beneficiaries when the face-to-face assessment indicates they do not meet medical necessity criteria and no specialty mental health services will be provided.

NOA-B: (Denial of Services) Denial or modification of provider's request for Medi-cal services requiring pre-authorization. The denial is sent from the point of authorization to both provider and beneficiary, when the beneficiary did not receive the service.

NOA-C: (Post-Service Denials) Denial or modification of provider's request for specialty mental health services sent from the point of authorization to both the provider and the beneficiary, when the beneficiary has already received the service.

NOA-D: (Delayed Grievance/Appeal Decisions) Notice sent by advocacy contractor to the beneficiary when the resolution of the grievance, appeal or expedited appeal was not provided within the required timeframe.

NOA-E: (Lack of Timely Services) Notice sent by provider to beneficiary when the provider does not provide services in a timely manner according to the MHP standards for timely services.

Patients' Rights Advocate:

The persons designated under Welfare and Institutions Code, Section 5500 et seq. to protect the rights of all recipients of specialty mental health services. The Patients' Rights Advocate "shall have no direct or indirect clinical or administrative responsibility for any recipient of Medi-Cal Managed Care Services, and shall have no other responsibilities that would otherwise compromise his or her ability to advocate on behalf of specialty mental health beneficiaries."

JFS Patient Advocacy Program staff currently serve as the Patients' Rights Advocate for acute inpatient and other 24-hour residential services, and CCHEA staff serve as the Patients' Rights Advocate for outpatient, day treatment, and all other services.

Quality Improvement (QI) Program:

The Quality Improvement Program is a unit within HHSA Mental Health Services whose duties include monitoring and oversight of the Grievance and Appeal Process.

**BENEFICIARY AND CLIENT PROBLEM RESOLUTION
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| | |
|--|---|
| State Fair Hearing: | A formal hearing before an administrative law judge, requested by a Medi-Cal beneficiary and conducted by the State Department of Social Services as described in Welfare and Institutions Code, Section 10950, and Federal Regulations Subpart E, Section 431.200 et seq. |
| Jewish Family Service (JFS) Patient Advocacy Program: | The Jewish Family Service Patient Advocacy Program is an agency currently designated by the Local Mental Health Director to fulfill two roles: to operate the County’s Grievance and Appeal process for client problems in acute care hospitals and residential services; and to provide patient advocacy services which include information and education on patient rights and individual client assistance in resolving problems with possible violations of patient’s rights. |

County of San Diego
Medi-Cal Specialty Mental Health Program
NOTICE OF ACTION
(Assessment)

Date: _____

To: _____, Medi-Cal Number: _____

The mental health plan for San Diego County has decided, after reviewing the results of an assessment of your mental health condition, that your mental health condition does not meet the medical necessity criteria to be eligible for specialty mental health services through the plan.

In the mental health plan's opinion, your mental health condition did not meet the medical necessity criteria, which are covered in the state regulations at Title 9, California Code of Regulations (CCR), Section 1830.205, for the reason checked below:

- ☐ Your mental health diagnosis as identified by the assessment is not covered by the mental health plan (Title 9, CCR, Section 1830.205(b)(1)).
- ☐ Your mental health condition does not cause problems for you in your daily life that are serious enough to make you eligible for specialty mental health services from the mental health plan (Title 9, CCR, Section 1830.205(b)(2)).
- ☐ The specialty mental health services available from the mental health plan are not likely to help you maintain or improve your mental health condition (Title 9, CCR, Section 1830.205(b)(3)(A) and (B)).
- ☐ Your mental health condition would be responsive to treatment by a physical health care provider (Title 9, CCR, 1830.205(b)(3)(C)).

If you agree with the plan's decision, and would like information about how to find a provider outside the plan to treat you, you may call and talk to a representative of the Access and Crisis Line at (800) 479-3339.

If you don't agree with the plan's decision, you may do one or more of the following:

You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of your mental health plan through the Access and Crisis Line at (800) 479-3339 or write to: Optum Access and Crisis Line, P.O. Box 601370, San Diego, CA 92160-1370.

You may file an appeal with your mental health plan. For inpatient/residential services, you may call and talk to or write a representative of JFS Patient Advocacy Program at (800) 479-2233, 2710 Adams Avenue, San Diego, CA 92116. For outpatient and all other mental health services, you may call and talk to or write a representative of the Consumer Center for Health Education and Advocacy at (877) 734-3258, 1764 San Diego Avenue, Suite 200, San Diego, CA 92110. Or you can follow the directions in the information pamphlet the mental health plan has given you. You must file an appeal within 90 days of the date of this notice. In most cases the mental health plan must make a decision on your appeal within 45 days of your request. You may request an expedited appeal, which must be decided within 3 working days, if you believe that a delay would cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions.

If you have questions about this notice, for inpatient/residential services, you may call and talk to or write a representative of JFS Patient Advocacy Program at (800) 479-2233, 2710 Adams Avenue, San Diego, CA 92116. For outpatient and all other mental health services, you may call and talk to or write a representative of the Consumer Center for Health Education and Advocacy at (877) 734-3258, 1764 San Diego Avenue, Suite 200, San Diego, CA 92110.

If you are dissatisfied with the outcome of your appeal, you may request a State Fair Hearing. The other side of this form will explain how to request a hearing.

**County of San Diego
Medi-Cal Specialty Mental Health Services Program
NOTICE OF ACTION**

Date: _____

To: _____ Medi-Cal Number _____

The mental health plan for San Diego County has ☐ denied ☐ changed your provider's request for payment of the following service(s):

The request was made by: (provider name) _____

The original request from your provider was dated _____

The mental health plan took this action based on information from your provider for the reason checked below:

☐ Your mental health condition does not meet the medical necessity criteria for psychiatric inpatient hospital services or related professional services (Title 9, California Code of Regulations (CCR), Section 1820.205).

☐ Your mental health condition does not meet the medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services for the following reason (Title 9, CCR, Section 1830.205): _____

☐ The service requested is not covered by the mental health plan (Title 9, CCR, Section 1810.345).

☐ The mental health plan requested additional information from your provider that the plan needs to approve payment of the proposed service. To date, the information has not been received.

☐ The mental health plan will pay for the following service(s) instead of the service requested by your provider, based on the available information on your mental health condition and service needs: _____

☐ Other: _____

If you don't agree with the plan's decision, you may:

1. You may file an appeal with your mental health plan. To do this, you may call and talk to a representative of your mental health plan at (800) 479-3339 or write to: Utilization Management, Optum, P.O. Box 601370, San Diego, CA 92160-1370; or follow the directions in the information brochure the mental health plan has given you. You must file an appeal within 90 days of the date of this notice. In most cases the mental health plan must make a decision on your appeal within 45 days of your request. You may request an expedited appeal, which must be decided within 3 working days, if you believe that a delay would cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions. You can request that your services stay the same until an appeal decision is made. To keep your services you must file an appeal within 10 days of the date of this notice or before the effective date of the change in services, whichever is later. The services requested were previously approved by the plan for the period _____. The effective date for the change in these services is _____.
2. If you are dissatisfied with the outcome of your appeal, you may request a state hearing which may allow services to continue while you wait for the hearing. The other side of this notice explains how to request a hearing. You can request that your services stay the same until a hearing decision is made. To keep your services you must file an appeal within 10 days of the date of this notice or before the effective date of the change in services, whichever is later. The services requested were previously approved by the plan for the period _____. The effective date for the change in these services is _____. The services may continue while you wait for a resolution of your hearing.
3. You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of your mental health plan at (800) 479-3339 or write to: Utilization Management, Optum, P.O. Box 601370, San Diego, CA 92160-1370.

YOUR HEARING RIGHTS

You only have 90 days to ask for a hearing. The 90 days start either:

1. The day after we personally gave you this the mental health plan's appeal decision notice, OR
2. The day after the postmark date of this mental health plan's appeal decision notice.

Expedited State Hearings

It usually takes about 90 days from the date of your request to make a hearing decision. If you think this timing will cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions, you may request an expedited state hearing. **To request an expedited hearing, please check the first box in the right hand column of this page under HEARING REQUEST and include the reason why you are requesting an expedited hearing.** If your expedited hearing request is approved, a hearing decision will be issued within three working days of the date your request is received by the State Hearings Division.

To Keep Your Same Services While You Wait for a Hearing

- You must ask for a hearing within 10 days from the date the mental health plan's appeal decision notice was mailed or personally given to you or before the effective date of the change in services, whichever is later.
- Your Medi-Cal mental health services will stay the same until a final hearing decision is made which is adverse to you, you withdraw your request for a hearing, or the time period or service limits for your current services expire, whichever happens first.

State Regulations Available

State regulations, including those covering state hearings, are available at your local county welfare office.

To Get Help

You may get free legal help at your local legal aid office or other groups. For problems with inpatient and residential mental health services, call JFS Patient Advocacy Program at 800-479-2233. For problems with outpatient and all other mental health services, call toll free the Consumer Center for Health Education and Advocacy at 877-734-3258. You can ask about your hearing rights or free legal aid from the Public Inquiry and Response Unit:

Call toll free: 1-800-952-5253

If you are deaf and use TDD, call: 1-800-952-8349

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, an attorney or anyone else you choose. You must arrange for this representative yourself.

Information Practices Act Notice (California Civil Code Section 1798, et seq.) The information you are asked to write in on this form is needed to process your hearing request. Processing may be delayed if the information is not complete. A case file will be set up by the State Hearings Division of the Department of Social Services. You have the right to examine the materials that make up the record for decision and may locate this record by contacting the Public Inquiry and Response Unit (phone number shown above). Any information you provide may be shared with

the mental health plan, the State Departments of Health Services and Mental Health and with the U.S. Department of Health and Human Services (Authority: Welfare and Institutions Code, Section 14100.2)

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then send this page to:

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call 1-800-952-8349.

HEARING REQUEST

I want a hearing because of a Medi-Cal related action by the Mental Health Plan of San Diego County.

- ☐ Check here if you want an expedited state hearing and include the reason below.

Here's why: _____

- ☐ Check here and add a page if you need more space.

My Name: (print) _____

My Social Security Number: _____

My Address: (print) _____

My Phone Number: () _____

My Signature: _____

Date: _____

I need an interpreter at no cost to me. My language or dialect is: _____

I want the person named below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.

Name: _____

Address: _____

Phone Number: () _____

Condado de San Diego
Programa de Especialidades de Salud Mental de Medi-Cal
AVISO DE ACCIÓN
(Evaluación)

Fecha: _____

Para: _____ Número de Medi-Cal _____

El plan de salud mental del Condado de San Diego ha decidido, después de revisar los resultados de la evaluación de su condición mental, que su condición mental no cumple con el criterio de necesidad médica para ser elegible para recibir servicios de salud mental especializados a través del plan.

En opinión del plan de salud, su condición de salud mental no cumple con el criterio de necesidad médica que se encuentra cubierto en los reglamentos estatales, Título 9, Sección 1830.205 del Código de Regulaciones de California (CCR), por la razón que se marca a continuación:

- ☐ Su diagnóstico de salud mental, según se identifica por medio de la evaluación, no está cubierto por el plan de salud mental (Título 9, Sección 1830.205 (b)(1) CCR).
- ☐ Su condición de salud mental no le ocasiona problemas suficientemente serios en su vida diaria como para que usted sea elegible para recibir servicios de salud mental especializados de su plan de salud mental (Título 9, Sección 1830.205 (b)(2) CCR).
- ☐ No es probable que los servicios especializados de salud mental con los que cuenta su plan de salud le ayuden a mantener o mejorar su condición de salud mental (Título 9, Sección 1830.205 (b)(3)(A) y (B)) CCR).
- ☐ Su condición de salud mental respondería al tratamiento proporcionado por un proveedor de salud física (Título 9, Sección 1830.205 (b)(3)(C) CCR).

Si usted está de acuerdo con la decisión tomada por el plan y le gustaría obtener información sobre como encontrar un proveedor para su tratamiento alternativo a este plan, llame y hable con un representante de la Línea de acceso y ayuda para casos de crisis (San Diego Access and Crisis Line) al 1-800-479-3339.

Si usted no está de acuerdo con la decisión tomada por el plan:

Puede pedirle al plan que le tramite una segunda opinión acerca de su condición de salud mental. Para hacer esto, puede llamar y hablar con un representante de la Línea de acceso y ayuda para casos de crisis (San Diego Access and Crisis Line) al 1-800-479-3339 o escriba a: Optum al P.O. Box 601370, San Diego, CA 92160-1370.

Puede presentar una apelación a su plan de salud mental. Para servicios para pacientes internos/residenciales, puede llamar o escribir a un representante del Programa de Intercesión a Favor del Paciente al (800) 479-2233, 2710 Adams Avenue, San Diego, CA 92116. Para pacientes ambulatorios y para todos los demás servicios de salud mental puede llamar o escribir a un representante del Centro del Consumidor para Intercesión y Educación sobre la Salud al (877) 734-3258, 1764 San Diego Avenue, Suite 200, San Diego, CA 92110, o seguir las instrucciones en el folleto de información que le entregó el plan de salud mental. Usted debe presentar la apelación dentro de los 90 días posteriores a la fecha de este aviso. En la mayoría de los casos el plan de salud mental debe tomar una decisión sobre su apelación dentro de los 45 días posteriores a su solicitud. Si usted piensa que un retraso podría ocasionar serios problemas a su salud mental, como problemas relacionados con su capacidad de adquirir, mantener o recuperar funciones vitales importantes, entonces puede solicitar una apelación expedita, en la que la decisión debe tomarse en un período de tres días hábiles.

Si tiene preguntas acerca de este aviso, para servicios para pacientes internos/residenciales, puede llamar o escribir a un representante del Programa de Intercesión a Favor del Paciente al (800) 479-2233, 2710 Adams Avenue, San Diego, CA 92116. Para pacientes ambulatorios y para todos los demás servicios de salud mental puede llamar o escribir a un representante del Centro del Consumidor para Intercesión y Educación sobre la Salud al (877) 734-3258, 1764 San Diego Avenue, Suite 200, San Diego, CA 92110.

Si no esta satisfecho con el resultado de su apelación, usted puede solicitar una Audiencia Imparcial del Estado. Al reverso de este formulario se explica cómo solicitar una audiencia.

Quận Hạt San Diego
Chương Trình Dịch Vụ Sức Khỏe Tâm Thần của Chuyên Ngành Medi-Cal
BẢNG THÔNG BÁO
(Sự Giám Định)

Ngày tháng _____

Kính gửi _____, Thẻ Medi-cal số _____

Sau khi giám định tình trạng sức khỏe tâm thần của quý vị, Chương trình sức khỏe tâm thần Quận hạt San Diego nhận thấy tình trạng của quý vị không hội đủ tiêu chuẩn cần thiết để có quyền hưởng dịch vụ tâm thần qua chương trình của chúng tôi..

Thep ý kiến của của chương trình sức khỏe tâm thần, tình trạng sức khỏe tâm thần của quý vị không hội đủ tiêu chuẩn y tế cần thiết để được trả tiền theo Luật Title 9 của tiểu bang, California Code of Regulations (CCR), Phần 1830.205, vì những lý do sau đây::

- ☐ Sau khi giám định, tình trạng sức khỏe tâm thần của quý vị được xác nhận là không đủ tiêu chuẩn hưởng chương trình sức khỏe tâm thần (Luật Title 9, California Code of Regulations, Phần 1830.205(b)(1)).
- ☐ Tình trạng sức khỏe tâm thần của quý vị không gây cản trở nghiêm trọng trong đời sống hàng ngày để quý vị có thể hội đủ điều kiện nhận dịch vụ sức khỏe tâm thần đặc biệt của chúng tôi (Luật Title 9, California Code of Regulations, Phần 1830.205(b)(2)).
- ☐ Các dịch vụ sức khỏe tâm thần gần như không hiệu quả gì cho quý vị trong việc duy trì và cải tiến tình trạng sức khỏe tâm thần của quý vị (Luật Title 9, California Code of Regulations, Phần 1830.205(b)(3)(A) và (B)).
- ☐ Tình trạng sức khỏe tâm thần của quý vị có thể có hiệu quả nếu đi khám bác sĩ chăm sóc sức khỏe tổng quát (Luật Title 9, California Code of Regulations, Phần 1830.205(b)(3)(C)).

Nếu quý vị đồng ý với sự quyết định này, và muốn biết thêm chi tiết về việc tìm bác sĩ bên ngoài chương trình, quý vị có thể gọi điện thoại và thảo luận với người đại diện chương trình sức khỏe tâm thần của quý vị ở số (800) 479-3339 hay viết thư cho: Utilization Management, Optum, P.O. Box 601370, San Diego, CA 92160-1370.

Nếu quý vị không đồng ý với quyết định của chương trình, quý vị có thể làm một hay những điều sau đây:

Quý vị có quyền yêu cầu chương trình sắp xếp để xin ý kiến thứ hai về tình trạng sức khỏe tâm thần của quý vị. Để làm việc này, quý vị có thể gọi và thảo luận với người đại diện chăm sóc sức khỏe tâm thần của quý vị ở số (800) 479-3339 hay viết thư cho: Utilization Management, Qr wo , P.O. Box 601370, San Diego, CA 92160-1370.

Quý vị có thể mở hồ sơ khiếu nại với chương trình sức khỏe tâm thần. Với bệnh nhân đang nằm bệnh viện/hay dịch vụ tại gia, quý vị có thể gọi điện thoại và thảo luận hay viết thư cho người đại diện của chương trình Bệnh Vực Quyền Lợi JFS ở số (800) 479-2233, 2710 Adams, San Diego, CA 92116. Với bệnh nhân ngoại viện và tất cả những dịch vụ sức khỏe tâm thần, quý vị có thể gọi thảo luận hay viết thư cho người đại diện của Trung Tâm Tiêu Thụ về Giáo Dục Sức Khỏe và Bệnh Vực Quyền Lợi (Consumer Center for Health Education and Advocacy) ở số (877) 734-3258, 1986 Sep F lgi q"Ave, Ug"422, San Diego, CA 92130. Hay quý vị có thể làm theo sự hướng dẫn viết trong quyền chỉ dẫn sức khỏe tâm thần mà quý vị đã nhận. Quý vị phải mở hồ sơ khiếu nại trong vòng 90 ngày tính từ ngày nhận được thông báo này. Hầu hết các trường hợp, chương trình sức khỏe phải giải quyết trong vòng 45 ngày từ khi quý vị yêu cầu. Quý vị có thể yêu cầu một phiên xử để giải quyết sớm hơn bình thường, có nghĩa là vấn đề sẽ được giải quyết trong vòng 3 ngày làm việc nếu quý vị tin là sự trễ nãi sẽ khiến tình trạng bệnh tâm thần của mình trở nên trầm trọng, bao gồm việc ảnh hưởng không tốt đến khả năng duy trì hay hồi phục chức năng quan trọng của đời sống.

Nếu quý vị có câu hỏi liên quan đến thông báo này, với bệnh nhân nằm viện/ dịch vụ tại gia, quý vị có thể gọi thảo luận hay viết thư cho người đại diện của Chương Trình Bệnh vực Bệnh nhân của JFS ở số (800) 479-2233, 2710 Adams, San Diego, CA 92116. Với bệnh nhân ngoại viện và tất cả những dịch vụ sức khỏe tâm thần khác, xin quý vị gọi thảo luận hay viết cho người đại diện của Trung Tâm Tiêu Thụ về Giáo dục Sức Khỏe và Bệnh vực Quyền lợi (Consumer Center for Health Education and Advocacy) ở số (877) 734-3258, 1764 San Diego Ave, Ste 200, San Diego, CA 92110.

If you are dissatisfied with the outcome of your appeal, you may request a State Fair Hearing. The other side of this form will explain how to request a hearing.

QUYỀN ĐIỀU TRẦN

Quý vị chỉ có 90 ngày để yêu cầu buổi điều trần. 90 ngày bắt đầu:

1. Tính từ ngày chúng tôi đích thân đưa quý vị bản thông báo khiếu nại sức khỏe tâm thần này, HAY
2. Tính từ ngày dấu bưu điện in trên bản thông báo khiếu nại sức khỏe tâm thần này.

Buổi Điều trần Nhanh Chóng cấp Tiểu bang

Thường mất 90 ngày kể từ ngày quý vị yêu cầu. Nếu quý vị nghĩ thời gian này có thể gây nguy hại trầm trọng cho sức khỏe tâm thần của mình gồm việc duy trì và phục hồi các chức năng quan trọng của đời sống, quý vị có thể xin được xử nhanh hơn thường lệ. **Để có một buổi điều trần nhanh, xin vui lòng đánh dấu ô đầu tiên bên phải của trang này dưới chữ YÊU CẦU ĐIỀU TRẦN và ghi cả nguyên nhân yêu cầu được xử nhanh.** Nếu lời yêu cầu của quý vị được chấp nhận, người ta sẽ thông báo cho quý vị biết trong vòng ba ngày làm việc tính từ ngày Ủy Ban Điều Trần Tiểu bang nhận khiếu nại của quý vị.

Để được nhận cùng dịch vụ trong khi quý vị chờ đợi buổi Điều trần

- Quý vị phải yêu cầu có buổi điều trần trong vòng 10 ngày tính từ ngày bản thông báo khiếu nại sức khỏe tâm thần gửi đến hay được giao tận tay cho quý vị trước ngày thay đổi dịch vụ, tính theo việc nào xảy ra trễ hơn.
- Các dịch vụ sức khỏe tâm thần Medi-Cal sẽ vẫn giữ nguyên cho đến khi có quyết định cuối cùng của buổi điều trần và nếu kết quả bất lợi cho quý vị, và quý vị thu hồi lời yêu cầu, hay cho đến khi thời hạn nhận dịch vụ bị hết hạn, tính theo việc nào đến trước.

Các Luật Điều Hành Cấp Tiểu Bang

Luật điều hành tiểu bang, bao gồm tin tức điều trần đều có sẵn trong văn phòng trợ cấp xã hội của quận hạt địa phương.

Để được giúp đỡ

Quý vị có thể nhận được sự giúp đỡ pháp lý từ văn phòng trợ giúp pháp lý địa phương hay từ các nhóm khác. Về các vấn đề khó khăn với bệnh nhân nội trú hay các dịch vụ sức khỏe tâm thần tại gia, hãy gọi Chương trình Bệnh vực Bệnh nhân JFS ở số 800-479-2233. Về các vấn đề khó khăn với bệnh nhân ngoại viện và các dịch vụ sức khỏe tâm thần khác, hãy gọi số miễn phí đến Trung tâm Tiêu thụ Giáo dục Sức khỏe và Bệnh vực quyền lợi (Consumer Center for Health Education and Advocacy) ở số 877-734-3258. Quý vị có thể yêu cầu tin tức về quyền xin điều trần hay giúp đỡ pháp lý từ Public Inquiry and Response Unit:

Gọi số miễn phí : 1-800-952-5253

Nếu khiếm thính, gọi TDD, call: 1-800-952-8349

Người đại diện hợp pháp

Quý vị có thể tự điều trần trước phiên xử. Quý vị cũng có thể chọn một người bạn, một luật sư hay bất cứ ai đại diện cho mình. Quý vị phải tự mình sắp xếp việc này

Thông báo của Practices Act Notice (California Civil Code Section 1798, et seq.) Chi tiết mà quý vị được yêu cầu viết trong mẫu này rất cần thiết để xúc tiến buổi điều trần của quý vị. Việc xúc tiến có thể trễ nãi nếu chi tiết không đầy đủ. Hồ sơ sẽ được thiết lập bởi Bộ Xã Hội Tiểu bang, Bộ phận Điều trần. Quý vị có quyền tham khảo hồ sơ và biết nó ở đâu bằng cách liên lạc với Public Inquiry and Response Unit (điện thoại đã ghi bên trên). Bất

cứ chi tiết nào mà quý vị cung cấp, chúng tôi sẽ chia sẻ với chương trình sức khỏe tâm thần, với Bộ Dịch vụ Y tế và Sức Khỏe Tâm thần Tiểu bang và với Bộ Y tế và Nhân sinh của Liên bang (Authority: Welfare and Institutions Code, Section 14100.2)

CÁCH YÊU CẦU BUỔI ĐIỀU TRẦN CẤP TIỂU BANG

Cách hay nhất để yêu cầu được buổi điều trần là điền vào mẫu này. Làm bản sao phần trước và sau của mẫu này để lưu giữ vào hồ sơ của quý vị. Sau đó gửi trang này về:

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

Một cách khác để xin buổi điều trần là gọi điện thoại số 1-800-952-5253. Nếu quý vị bị khiếm thính thì dùng TDD, gọi số 1-800-952-8349.

YÊU CẦU ĐIỀU TRẦN

Tôi muốn có một buổi điều trần liên hệ đến Medi-Cal và Chương Trình Sức Khỏe Tâm Thần của Quận hạt San Diego.

☐ Đánh dấu trong ô này nếu quý vị muốn có một buổi điều trần nhanh chóng và viết nguyên nhân tại sao :.

Nguyên nhân:

☐ Đánh dấu vào ô này nếu muốn viết thêm một trang nữa.

Tên họ (chữ in) _____

Số An sinh xã hội: _____

Địa chỉ (chữ in) _____

Điện thoại: (_____) _____

Chữ ký: _____

Ngày tháng: _____

Tôi cần một thông dịch viên miễn phí. Ngôn ngữ gốc của tôi là _____

Tôi muốn người có tên dưới đây đại diện tôi trong buổi điều trần. Tôi cho phép người này xem hồ sơ của tôi và đến dự buổi điều trần cùng tôi.

Tên họ: _____

Địa chỉ: _____

Điện thoại: (_____) _____

Condado de San Diego
Programa de Servicios Especializados de Salud Mental de Medi-Cal
AVISO DE ACCIÓN

Fecha: _____

Para: _____ Número de Medi-Cal: _____

El plan de salud mental del Condado de San Diego ha ☐ negado ☐ cambiado la solicitud de su proveedor por el pago del siguiente(s) servicio(s):

La solicitud fue hecha por: (nombre del proveedor) _____

La solicitud original de su proveedor tenía fecha del _____.

El plan de salud mental tomó esta acción basándose en la información de su proveedor por la razón que se marca a continuación:

- ☐ Su condición de salud mental no cumple con el criterio de necesidad médica para recibir servicios como paciente internado en un hospital psiquiátrico ni para servicios profesionales relacionados (Título 9, Sección 1830.205 del Código de Regulaciones de California (CCR))
- ☐ Su condición de salud mental no cumple con el criterio de necesidad médica para recibir servicios de salud mental especializados que no sean servicios de hospital psiquiátrico como paciente internado, por la siguiente razón (Título 9, Sección 1830.205, CCR): _____
- ☐ El servicio que se solicita no está cubierto por el plan de salud mental (Título 9, Sección 1830.205, CCR).
- ☐ El plan de salud mental solicitó información adicional de su proveedor, la cual necesita para aprobar el pago del servicio propuesto. Hasta la fecha no se ha recibido dicha información.
- ☐ El plan de salud mental pagará por el/los siguientes servicios, en lugar de por los servicios solicitados por su proveedor, basándose en la información disponible sobre sus necesidades de servicio y su condición de salud mental:

- ☐ Otra _____

Si no está de acuerdo con la decisión tomada por el plan, usted puede:

1. Presentar una apelación a su plan de salud mental. Para hacer esto, puede llamar y hablar con un representante de su plan de salud mental al (800) 479-3339 o escribir a: Utilization Management, Optum, P.O. Box 601370, San Diego, CA 92160-1370 o seguir las instrucciones en el folleto de información que le entregó el plan de salud mental. Usted debe presentar la apelación dentro de los 90 días posteriores a la fecha de este aviso. En la mayoría de los casos el plan de salud mental debe tomar una decisión sobre su apelación dentro de los 45 días posteriores a su solicitud. Si piensa que un retraso podría ocasionar serios problemas a su salud mental, como problemas relacionados con su capacidad para adquirir, mantener o recuperar funciones vitales importantes entonces usted puede solicitar una apelación expedita, en la que la decisión debe tomarse en un período de tres días hábiles. Usted puede solicitar que sus servicios continúen igual hasta que se tome la decisión a su apelación. Para mantener sus servicios usted debe presentar la apelación dentro de los 10 primeros días a partir de la fecha de este aviso o antes de la fecha en que el cambio de servicios sea efectivo, lo que suceda después. Los servicios solicitados fueron previamente aprobados por el plan, por el período de _____. La fecha efectiva para el cambio de estos servicios es: _____
2. Solicitar una audiencia del estado si no está satisfecho(a) con el resultado a su apelación, lo que permitiría que usted siguiera recibiendo servicios mientras espera por dicha audiencia. Al reverso de este formulario se explica cómo solicitar la audiencia. Usted puede solicitar que sus servicios continúen igual hasta que se tome la decisión a su apelación. Para conservar sus servicios debe presentar la apelación dentro de los 10 primeros días a partir de la fecha de este aviso o antes de la fecha en que los cambios de servicios sean efectivos, lo que suceda después. Los servicios solicitados fueron previamente aprobados por el plan, por el período de _____. La fecha efectiva para el cambio de estos servicios es: _____. Los servicios pueden continuar mientras espera la resolución de su audiencia.
3. Puede pedirle al plan que haga arreglos para tener una segunda opinión sobre su condición de salud mental. Para hacer esto, puede llamar y hablar con un representante de su plan de salud mental al (800) 479-3339 o escribir a: Utilization Management, Optum, P. O. Box 601370, San Diego, CA 92160-1370.

Quận Hạt San Diego
Chương Trình Sức Khỏe Tâm Thần Chuyên Ngành Medi-Cal
THÔNG BÁO

Ngày tháng: _____

Kính gửi _____ Thẻ Medi-Cal số _____

Chương Trình Sức Khỏe Tâm Thần của Quận hạt San Diego đã ☐ từ chối ☐ đòi hỏi yêu cầu của cơ quan chăm sóc sức khỏe của quý vị về việc trả tiền các dịch vụ sau đây:

Lời yêu cầu do (tên của của cơ quan chăm sóc sức khỏe) _____

Yêu cầu đầu tiên của cơ quan ghi ngày _____

Chương trình sức khỏe tâm thần quyết định như thế này vì căn cứ vào chi tiết mà cơ quan chăm sóc sức khỏe của quý vị ghi nhận như sau:

- ☐ Tình trạng sức khỏe tâm thần của quý vị không hội đủ tiêu chuẩn cần thiết để hưởng dịch vụ tâm thần cung cấp trong bệnh viện hay các dịch vụ chuyên ngành (Luật Title 9, California Code of Regulations (CCR), Phần 1820.205).
- ☐ Tình trạng sức khỏe tâm thần của quý vị không hội đủ tiêu chuẩn cần thiết để nhận dịch vụ tâm thần chuyên ngành khác hơn là những dịch vụ tâm thần do bệnh viện cung cấp vì những lý do sau đây: (Luật Title 9, CCR, Phần 1830.205): _____
- ☐ Dịch vụ yêu cầu không được chương trình sức khỏe tâm thần trang trải (Luật Title 9, CCR, Phần 1810.345).
- ☐ Chương trình sức khỏe tâm thần yêu cầu cơ quan chăm sóc sức khỏe của quý vị cung cấp thêm chi tiết để chương trình xét và chấp nhận trả tiền các dịch vụ đề nghị. Đến giờ phút này mà chúng tôi vẫn chưa nhận được..
- ☐ Chương trình sức khỏe tâm thần sẽ trả tiền cho những dịch vụ kể dưới đây thay vì dịch vụ do cơ quan chăm sóc sức khỏe của quý vị yêu cầu, căn cứ vào những chi tiết về tình trạng sức khỏe tâm thần và dịch vụ cần thiết của quý vị: _____
- ☐ Những điều khác _____

Nếu quý không đồng ý với quyết định của chương trình, quý vị có thể:

1. Mở hồ sơ khiếu nại với chương trình sức khỏe tâm thần của mình. Để làm việc này, quý vị có thể gọi điện thoại và thảo luận với người đại diện chương trình ở số (800) 479-3339 hay viết thư cho: Utilization Management, Optum, P.O. Box 601370, San Diego, CA 92160-1370; hay làm theo lời chỉ dẫn trong quyển sách hướng dẫn mà quý vị đã nhận được. Quý vị phải mở hồ sơ khiếu nại trong vòng 90 ngày từ ngày nhận thông báo này. Hầu hết các trường hợp, chương trình sức khỏe tâm thần phải giải quyết khiếu nại của quý vị trong vòng 45 ngày từ lúc quý vị yêu cầu. Quý vị có thể yêu cầu giải quyết nhanh trong vòng ba ngày làm việc, nếu quý vị tin rằng sự giải quyết trễ nãi có thể gây hậu quả nghiêm trọng cho sức khỏe tâm thần, kể cả vấn đề duy trì, hồi phục các chức năng quan trọng của đời sống. Quý vị có thể yêu cầu được nhận dịch vụ cho đến khi có được quyết định của sự khiếu nại. Để giữ được những dịch vụ, quý vị phải mở hồ sơ khiếu nại trong vòng 10 ngày tính từ lúc nhận thông báo này hay trước ngày thay đổi những dịch vụ, tính theo việc nào xảy ra trễ hơn. Những dịch vụ được chương trình chấp nhận trước kia trong khoảng thời gian _____. Sự thay đổi những dịch vụ bắt đầu có hiệu lực từ ngày _____.
2. Nếu quý vị không bằng lòng kết quả của việc khiếu nại, quý vị có thể yêu cầu có một buổi điều trần cấp tiểu bang và quý vị vẫn tiếp tục nhận các dịch vụ trong khi chờ được điều trần. Trang sau của thông báo này có giải thích làm các h nào để xin buổi điều trần. Quý vị có thể yêu cầu giữ những dịch vụ như cũ cho đến khi có kết quả. Để giữ được dịch vụ, quý vị phải mở hồ sơ khiếu nại trong vòng 10 ngày tính từ lúc nhận thông báo này hay trước ngày thay đổi những dịch vụ, tính theo việc nào xảy ra trễ hơn. Những dịch vụ được chương trình chấp nhận trước kia trong khoảng thời gian _____. Sự thay đổi những dịch vụ bắt đầu có hiệu lực từ ngày _____. Các dịch vụ có thể vẫn tiếp tục trong khi quý vị chờ đợi kết quả của buổi điều trần.
3. Quý vị có thể yêu cầu chương trình sắp xếp để có một ý kiến thứ hai về tình trạng sức khỏe tâm thần của quý vị. Để làm việc này, quý vị có thể gọi và thảo luận với một người đại diện của chương trình sức khỏe tâm thần của quý vị ở (800) 479-3339 hay viết thư về: Utilization Management, Optum, P.O. Box 601370, San Diego, CA 92160-1370.

Distrito ng San Diego
Programa ng Pinagdalubhasaang Medi-Cal ng mga Serbisyo ng Kalusugang Kaisipan
PAUNANG -SABI NG PAG-GAWA

Petsa: _____

Para kay: _____ Numero ng Medi-Cal _____

Ang panukala ng kalusugang kaisipan para sa Distrito ng San Diego ay ☐ pinagkait ☐ binago sa kahilingan ng iyong tagapagkaloob para sa pagbabayad ng sumusunod na (nga) serbisyo:

Ang kahilingan ay ginawa ni: (pangalan ng taga-pagkaloob) _____

Ang orihinal na kahilingan ng iyong tagapagkaloob ay nakatala sa araw ng _____

Ang panukala ng kalusugang kaisipan ay nakuha ang pag-gawa batay sa inpormasyon ng iyong taga-pagkaloob sa dahilan ay tiyakin sa ibaba :

- ☐ Ang kalagayan ng iyong kalusugang kaisipan ay hindi nakasapat sa pamantayan na kinakailangan ng Medikal para sa mga serbisyo ng ospital na tumatanggap ng tirahan at pagkain kasama ang pag-gamot sa mga may sakit sa utak o kaugnay ng propesyonal na mga serbisyo (Title 9, California Code of Regulations (CCR), Section 1820.205).
- ☐ Ang kalagayan ng iyong kalusugang kaisipan ay hindi nakasapat ng pamantayan na kinakailangan ng Medikal para sa pinagdalubhasaang serbisyo ng kalusugang kaisipan bukod sa mga serbisyo ng ospital na tumatanggap ng tirahan at pagkain kasama ang pag-gamot sa mga may sakit sa utak para sa mga sumusunod na dahilan (Title 9, CCR, Section 1830.205): _____
- ☐ Ang serbisyo na hinihiling ay hindi napabilang batay sa panukala ng kalusugang kaisipan (Title 9, CCR, Section 1810.345).
- ☐ Ang panukala ng kalusugang kaisipan ay humihiling ng karagdagang inpormasyon na galing sa iyong taga-pagkaloob na ang panukala ay nangangailangan ng pahintulot para sa pagbabayad sa iminungkahing serbisyo. Sa araw na ito, ang inpormasyon ay hindi pa natatanggap.
- ☐ Ang panukala ng kalusugang kaisipan ay siyang magbabayad sa mga sumusunod ng (mga) serbisyo sa halip na hinihiling na serbisyo ng iyong taga-pagkaloob, batay sa nagagamit na inpormasyon ng iyong kalagayan ng kalusugang kaisipan at ang serbisyo na kinakailangan: _____
- ☐ Iba pa: _____

Kung ikaw ay hindi sang-ayon nitong panukalang pasiya, ikaw ay maaring:

1. Ikaw ay maaring magsampa ng panawagan kasama ng iyong panukala ng kalusugang kaisipan. Ang paggawa nito, ikaw ay maaring tumawag at kausapin ang representante ng iyong panukala ng kalusugang kaisipan sa (800) 479-3339 o sumulat sa: Utilization Management, Optum, P.O. Box 601370, San Diego, CA 92160-1370; o sundin ang mga direksyon nasa inpormasyon ng polyeto na ibinigay sa iyo ng panukala ng kalusugang kaisipan. Ikaw ay dapat mag-sampa ng panawagan sa loob ng 90 na araw mula sa petsa nitong paunang-sabi. Karamihan sa mga kalagayan ang panukala ng kalusugang kaisipan ay dapat gumawa ng pasiya ng iyong panawagan sa loob ng 45 na araw ng iyong paghiling. Ikaw ay maaring humiling ng mapabilis na panawagan, na kailangang mapasiyahan sa loob ng 3 gumaganang mga araw, kung ikaw ay naniniwala na pagnaatraso ito ay magiging dahilan ng malubhang mga problema ng iyong kalusugang kaisipan kasama na ang mga problema ng iyong kakayanang makamit, mapanatili, o mabawi ang mahalagang takbo ng buhay. Ikaw ay maaring humiling na ang iyong mga serbisyo ay manatiling walang pagkaiba hanggang ang pasiya ng panawagan ay magawa. Upang manatili ang iyong mga serbisyo kailangan mong magsampa ng panawagan sa loob ng 10 na araw mula sa petsa nitong paunang-sabi o bago ang petsa na mgkabisa ng pagpalit ng serbisyo, alinman ang huli. Ang serbisyo na hinihiling ay dating pinagsang-ayonan ng panukala para sa panahon _____. Ang petsa na magkabisa para sa pagpalit nitong serbisyo ay _____.
2. Kung ikaw ay hindi nasisiyahan sa resulta ng iyong panawagan, ikaw ay maaring humiling ng pormal na paghukom na maaring pahintulutang ipagpatuloy ang mga serbisyo habang ikaw ay naghihintay ng paghukom. Sa kabila nitong paunang-sabi ay nagpaliwanag kung paano humiling ng paghukom. Ikaw ay maaring humiling na ang iyong mga serbisyo ay manatiling walang pagkaiba hanggang ang paghukom ay magawa. Upang manatili ang iyong serbisyo kailangan mong magsampa ng panawagan sa loob ng 10 na araw mula sa petsa nitong paunang-sabi o bago ang petsa na magkabisa ng pagpalit sa serbisyo, alinman ang huli. Ang serbisyo na hinihiling ay dating pinagsang-ayonan ng panukala para sa panahon _____. Ang petsa na magkabisa para sa pagpalit nitong serbisyo ay _____. Ang mga serbisyo ay amaring magpatuloy habang ikaw ay naghihintay sa katatagan ng pasiya ng iyong hukom.
3. Ikaw ay maaring humiling sa panukala na mag-areglo ng pangalawang pagpalagay tungkol sa kalagayan ng iyong kalusugang kaisipan. Ang paggawa nito, ikaw ay maaring tumawag at kausapin ang representante ng iyong panukala ng kalusugang kaisipan sa (800) 479-3339 o sumulat sa: Utilization Management, Optum, P.O. Box 601370, San Diego, CA 92160-1370.

مقاطعة سان دييغو
برنامج خدمات الصحة النفسية المتخصصة بالتأمين الصحي الحكومي (Medi-Cal)
بيان إجرائي

التاريخ: _____

إلى: _____ رقم التأمين الصحي الحكومي: _____

إن برنامج الصحة النفسية لمقاطعة سان دييغو قد قرر ☐ رفض طلبك ☐ تغيير طلب موفر الخدمات الخاص بك لدفع تكاليف الخدمات التالية:

تم تقديم الطلب من قبل: (إسم موفر الخدمات) _____

تأريخ الطلب الأصلي المقدم من قبل موفر الخدمات الخاص بك: _____

إن برنامج خدمات الصحة النفسية هذا القرار اعتماداً على البيانات الواردة من موفر الخدمات الخاص بك و ذلك للأسباب المبينة أدناه:

☐ إن حالة صحتك النفسية لا تحقق المعايير الطبية الضرورية للحصول على خدمات مستشفى الصحة النفسية السريرية أو الخدمات المتخصصة المتعلقة بالصحة النفسية (المادة ٩، CCR، الفقرة ١٨٢٠,٢٠٥).

☐ إن حالة صحتك النفسية لا تحقق المعايير الطبية الضرورية للحصول على خدمات الصحة النفسية المتخصصة باستثناء خدمات مستشفى الصحة النفسية السريرية و ذلك بسبب (المادة ٩، CCR، الفقرة ١٨٣٠,٢٠٥): _____

☐ الخدمات المطلوبة غير مشمولة في برنامج الصحة النفسية (المادة ٩، CCR، الفقرة ١٨١٠,٣٤٥).

☐ لقد طلب برنامج الصحة النفسية المزيد من المعلومات من موفر الخدمات الخاص بك، يحتاج البرنامج لتلك المعلومات للموافقة على دفع تكاليف الخدمات المطلوبة. لغاية الآن لم يتم إستلام المعلومات المطلوبة.

☐ سيقوم برنامج الصحة النفسية بدفع تكاليف الخدمات التالية بدلاً عن الخدمات التي تم طلبها من قبل موفر الخدمات الخاص بك، اعتماداً على المعلومات المتوفرة عن حالة صحتك النفسية و إحتياجك للخدمات. _____

☐ أخرى: _____

إن لم توافق على قرار البرنامج فيمكنك:

١. يمكنك أن تقدم طلب إستئناف لبرنامج الصحة النفسية الخاص بك. لقيام بذلك، يمكنك الإتصال و التكلم مع ممثل عن برنامج الصحة النفسية على الهاتف المرقم ٤٧٩-٣٣٣٩ (٨٠٠) أو بمراسلة العنوان التالي: Utilization Management, Qr wo , P.O. Box 601370, San F lgi q. CA 92160-1370، أو بإتباع الإجراءات الواردة في كتيب المعلومات الذي قام برنامج الصحة النفسية بإعطائك إياه. يجب أن تقوم بتقديم طلب الإستئناف خلال ٩٠ يوماً من تأريخ هذا البيان. في أغلب الحالات، يجب أن يقوم برنامج الصحة النفسية بإتخاذ قرار بخصوص طلب الإستئناف الذي تقدمت به خلال ٤٥ يوماً من تأريخ تقديمك للطلب. يمكنك أن تطلب الحصول على إستئناف مستعجل، و الذي يجب أن يتم إتخاذ قرار بخصوصه خلال ٣ أيام عمل، إن كنت تعتقد بأن التأخير قد يؤدي إلى مشاكل جدية على صحتك النفسية، مثل المشاكل المتعلقة بقدرتك على إكتساب أو الحفاظ أو إستعادة بعض وظائف الحياة المهمة. يمكنك أن تطلب الإبقاء على الخدمات التي تحصل عليها حتى يتم إتخاذ قرار بخصوص طلب الإستئناف الذي تقدمت به. للإبقاء على الخدمات التي تحصل عليها، يجب أن تقوم بتقديم طلب الإستئناف خلال ١٠ أيام من تأريخ هذا البيان أو قبل تأريخ نفاذ التغيير في الخدمات، أيهما أبعد. لقد وافق البرنامج من قبل على الخدمات المطلوبة للفترة _____ تأريخ نفاذ التغيير في هذه الخدمات هو _____.

٢. إن لم تكن راضياً عن نتيجة الإستئناف، يمكنك أن تطلب الحصول على جلسة إستماع عادلة، ذلك قد يسمح بإستمرارك بالحصول على الخدمات أثناء فترة إنتظارك للجلسة. ستبين الصفحة الثانية من هذا البيان كيف يمكنك طلب الحصول على جلسة الإستماع. يمكنك أن تطلب الإبقاء على الخدمات التي تحصل عليها حتى يتم إتخاذ قرار جلسة الإستماع. للإبقاء على الخدمات التي تحصل عليها، يجب أن تقوم بتقديم طلب الإستئناف خلال ١٠ أيام من تأريخ هذا البيان أو قبل تأريخ نفاذ التغيير في الخدمات، أيهما أبعد. لقد وافق البرنامج من قبل على الخدمات المطلوبة للفترة _____ تأريخ نفاذ التغيير في هذه الخدمات هو _____ قد تستمر بالحصول على الخدمات أثناء إنتظارك لقرار جلسة الإستماع.

٣. يمكنك أن تطلب من البرنامج الترتيب للحصول على رأي آخر بخصوص حالة صحتك النفسية. للقيام بذلك، يمكنك الإتصال و التكلم مع ممثل عن برنامج الصحة النفسية على الهاتف المرقم ٤٧٩-٣٣٣٩ (٨٠٠) أو بمراسلة العنوان التالي: Utilization Management, Qr wo , "RQ0Dqz"823592. San Diego, CA 92160-1370

مقاطعة سان دييغو
برنامج خدمات الصحة النفسية المتخصصة بالتأمين الصحي الحكومي (Medi-Cal)
بيان إجرائي
(تقييم)

التأريخ: _____

إلى: _____

، رقم التأمين الصحي الحكومي: _____

قرر برنامج الصحة النفسية في مقاطعة سان دييغو، بعد مراجعة نتائج تقييم حالة صحتك النفسية، بأن حالة صحتك النفسية لا تحقق المعايير الضرورية لتكون مؤهلاً للحصول على خدمات الصحة النفسية المتخصصة ضمن البرنامج.

من وجهة نظر برنامج الصحة النفسية، فإن حالة صحتك النفسية لم تحقق المعايير الطبية الضرورية الواردة في أنظمة الولاية ضمن المادة 9، من قانون الأنظمة في ولاية كاليفورنيا (California Code of Regulations (CCR)، الفقرة 1830.205، وذلك للسبب المؤشر إزاءه أدناه:

☐ إن حالة صحتك النفسية كما تم تشخيصها في عملية التقييم غير مشمولة في خدمات برنامج الصحة النفسية (المادة 9، CCR، الفقرة 1830.205 (ب) (1)).

☐ إن حالة صحتك النفسية لا تسبب لك مشاكل جدية في حياتك اليومية بشكل يجعلك مؤهلاً للحصول على خدمات الصحة النفسية المتخصصة المقدمة من قبل برنامج خدمات الصحة النفسية (المادة 9، CCR، الفقرة 1830.205 (ب) (2)).

☐ لا يُعتقد بأن خدمات الصحة النفسية المتخصصة المتوفرة لدى برنامج الصحة النفسية ستساعدك على الحفاظ أو تحسين حالة صحتك النفسية (المادة 9، CCR، الفقرة 1830.205 (ب) (3) (أ) و (ب)).

☐ إن حالة صحتك النفسية تستجيب للعلاج المقدم من قبل موفر خدمات صحية بدنية (المادة 9، CCR، الفقرة 1830.205 (ب) (3) (ج)).

إن وافقت على قرار البرنامج، و كنت ترغب بالحصول على المعلومات المتعلقة بإيجاد موفر خدمات خارج البرنامج للمساعدة على علاج حالتك، يمكنك الإتصال و التكم مع ممثل عن برنامج الصحة النفسية على الهاتف المرقم 479-3339 (800) أو بمراسلة العنوان التالي: Utilization Management, Qr wo . P.O. Box 601370, San Diego, CA 92160-1370

إن لم توافق على قرار البرنامج، فيمكنك القيام بأي من الإجراءات التالية:

يمكنك أن تطلب من البرنامج الترتيب للحصول على رأي آخر بخصوص حالة صحتك النفسية. للقيام بذلك، يمكنك الإتصال و التكم مع ممثل عن برنامج الصحة النفسية على الهاتف المرقم 479-3339 (800) أو بمراسلة العنوان التالي: Utilization Management, Qr wo , P.O. Box 823592. San Diego, CA 92160-1370

يمكنك أن تقدم طلب إستئناف لبرنامج الصحة النفسية الخاص بك. للخدمات السريرية/أو لخدمات الإقامة، يمكنك الإتصال و التكم مع ممثل برنامج الدفاع عن حقوق المرضى (JFS) على الهاتف المرقم 479-2233 (800) أو مراسلته على العنوان التالي 2710 Adams Avenue, San Diego, CA 92116. أما بالنسبة لخدمات العيادة الخارجية و باقي خدمات الصحة النفسية، يمكنك الإتصال و التكم مع ممثل مركز التوعية و التنقيف الصحي للمستهلك على الهاتف المرقم 734-3258 (877) أو مراسلته على العنوان التالي 1986 Scp'Flgi q Ave, Uq'422, San Diego, CA 92130. أو يمكنك إتباع التوجيهات الواردة في كتيب المعلومات الذي أعطاك إياه برنامج الصحة النفسية. يجب أن تقوم بتقديم طلب الإستئناف خلال 90 يوماً من تأريخ هذا البيان. في أغلب الحالات، يجب أن يقوم برنامج الصحة النفسية باتخاذ قرار بخصوص طلب الإستئناف الذي تقدمت به خلال 45 يوماً من تأريخ تقديمك للطلب. يمكنك أن تطلب الحصول على إستئناف مستعجل، و الذي يجب أن يتم إتخاذ قرار بخصوصه خلال 3 أيام عمل، ذلك إن كنت تعتقد بأن التأخير قد يؤدي إلى حصول مشاكل جدية تؤثر على صحتك النفسية، مثل المشاكل المتعلقة بقدرتك على إكتساب أو الحفاظ أو إستعادة بعض وظائف الحياة المهمة.

إن كان لديك إستفسارات بخصوص هذا البيان، للخدمات السريرية/أو لخدمات الإقامة، يمكنك الإتصال و التكم مع ممثل برنامج الدفاع عن حقوق المرضى (JFS) على الهاتف المرقم 479-2233 (800) أو مراسلته على العنوان التالي 2710 Adams Avenue, San Diego, CA 92116. بالنسبة لخدمات العيادة الخارجية و باقي خدمات الصحة النفسية، يمكنك الإتصال و التكم مع ممثل مركز التوعية و التنقيف الصحي للمستهلك على الهاتف المرقم 734-3258 (877) أو مراسلته على العنوان التالي 1986 Scp'Flgi q Ave, Uq'422, San Diego, CA 92130. أو يمكنك إتباع التوجيهات الواردة في كتيب المعلومات الذي أعطاك إياه برنامج الصحة النفسية.

إن لم تكن راضياً عن نتيجة الإستئناف، فيمكنك أن تطلب الحصول على جلسة إستماع عادلة على مستوى الولاية. ستبين الصفحة الثانية من هذا البيان كيف يمكنك طلب الحصول على جلسة الإستماع.

كيف يمكنك طلب الحصول على جلسة إستماع على مستوى الولاية

أفضل طريقة لطلب جلسة إستماع هي ب تعبئة حقول هذه الصفحة. قم بإستنساخ كلاً من وجهي هذه الورقة للإحتفاظ به في ملفاتك الخاصة. بعد ذلك، قم بإرسال هذه الورقة إلى العنوان التالي:

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

كما يمكنك طلب الحصول على جلسة إستماع عن طريق الهاتف ب الإتصال بالهاتف 1-800-952-5253. إن كنت أصماً ومن الذين يستخدمون نظم الإتصال الخاصة بالصم، يمكنك الإتصال بالهاتف المرقم 1-800-952-8349.

طلب الحصول على جلسة إستماع

أرغب بطلب جلسة إستماع بسبب الإجراءات المتعلقة ببرنامج التأمين الصحي الحكومي (Medi-Cal) المتخدة من قبل برنامج الصحة النفسية التابع لمقاطعة سان دييغو.

قم بتأشير هذا المربع إن كنت ترغب بالحصول على جلسة إستماع عاجلة و قم ب توضيح الأسباب أدناه.

الأسباب:

قم بتأشير هذا المربع و أضف صفحة أخرى إن إحتجت إلى مجال أكبر لشرح الأسباب.

إسمي: (أكتب بوضوح)

رقم الضمان الإجتماعي الخاص بي:

عنواني: (أكتب بوضوح)

رقم هاتفي: ()

توقيعي:

التاريخ:

إنني أحتاج لمترجم مجاني. لغتي أو لهجتي هي:

إنني أرغب أن يمثلني الشخص المذكور أدناه خلال جلسة الإستماع. إنني أمنح هذا الشخص حق مطالعة سجلاتي الخاصة و حق حضور جلسة الإستماع بدلاً عني.

الإسم:

العنوان:

رقم الهاتف:

حقوقك المتعلقة بالحصول على جلسة إستماع

- لديك 90 يوماً لطلب الحصول على جلسة إستماع. تبدأ فترة الـ 90 يوماً إعتباراً من:
- اليوم الذي قمنا فيه بتسليمك شخصياً هذا ال بيان المتعلق بقرار الإستئناف الصادر عن برنامج الصحة النفسية ، أو
 - اليوم الذي يلي اليوم الذي ختم به هذا البيان بختم مكتب البري د.

طلب الحصول على جلسة إستماع عاجلة على مستوى الولاية

عادة ما يستغرق إتخاذ القرار 90 يوماً من تأريخ تقديمك لطلب الحصول على قرار جلسة الإستماع. يمكنك طلب الحصول على جلسة إستماع عاجلة إن كنت تعتقد أن هذه الفترة ستسبب مشاكل خطيرة على صحتك النفسية، بضمن ذلك ، المشاكل التي قد تؤثر على إستعادة أو المحافظة على قدرتك على ممارسة نشاطات الحياة الضرورية. **لطلب الحصول على جلسة إستماع عاجلة، يرجى أن تأشر في المربع الأول في العمود الأيسر لهذه الصفحة**

المعنون طلب الحصول على جلسة إستماع و أن تبين الأسباب التي دعتك إلى طلب الحصول على جلسة إستماع عاجلة. إن تمت الموافقة على طلبك الخاص بجلسة الإستماع العاجلة، فسيتم إتخاذ قرار خلال ثلاثة أيام عمل من تأريخ إستلام طلبك من قبل قسم جلسات الإستماع في الولاية.

من أجل إستمرارك بالحصول على ذات الخدمات أثناء إنتظارك لجلسة الإستماع

- يجب أن تطلب الحصول على جلسة إستماع خلال 10 أيام من تأريخ إرسال بيان قرار الإستئناف الصادر عن برنامج الصحة النفسية أو من تأريخ تسليمه إليك شخصياً؛ أو قبل تأريخ فإذ التغييرات الطارئة على الخدمات ، أيهم أبعد.
- ستستمر خدمات الصحة النفسية التي تحصل عليها من قبل برنامج التأمين الصحي الحكومي (Medi-Cal) كما هي حتى يتم إتخاذ قرار نهائي ل جلسة الإستماع لا يصعب في مصلحتك، أو تقوم بسحب طلبك بالحصول على جلسة إستماع، أو عندما تنتهي فترة أو حدود الخدمات، أيهم أقرب.

توفر نصوص أنظمة الولاية

أنظمة الولاية، بضمنها تلك الأنظمة المتعلقة بجلسات الإستماع متوفرة في مكتب دائرة الضمان الإجتماعي في مقاطعتك.

للحصول على المساعدة

يمكنك الحصول على المساعدة القانونية مجاناً من مكتب المشورة القانونية المحلي أو من قبل المجموعات الأخرى. للمشاكل المتعلقة بخدمات الصحة النفسية السريرية أو المقيمة، إتصل ببرنامج الدفاع عن حقوق المريض (JFS) على الهاتف المرقم 800-479-2233. للمشاكل المتعلقة بالعيادة الخارجية و لكافة خدمات الصحة النفسية الأخرى، يرجى الإتصال مجاناً بمركز التثقيف و التوعية الصحية للمستهلك على الهاتف المرقم 877-734-3258. يمكنك أن تحصل على المعلومات المتعلقة بحقوقك الخاصة بجلسة الإستماع و المشورة القانونية المجانية من قبل وحدة الإستفسارات و الإجابات العامة.

يرجى الإتصال على الهاتف المجاني

1-800-952-5253
إن كنت أصماً و تستعمل نظم الإتصال الخاصة بالصم 1-800-952-8349

الممثل المخول

يمكنك أن تمثل نفسك في جلسة الإستماع. كما و يمكن أن تمثل من قبل صديق، أو محامي أو أي شخص آخر تختاره. يجب أن تقوم بإختيار هذا الممثل بنفسك.

بيان قانون إستخدام المعلومات (القانون المدني لولاية كاليفورنيا المادة 1798)

إن المعلومات المطلوبة منك في هذه الإستمارة هي معلومات ضرورية لإجراءات طلب الإستئناف الخاص بك. يمكن أن تتأخر تلك الإجراءات إن لم تكن هذه المعلومات كاملة و دقيقة. سيتم إستحداث ملف خاص بالقضية من قبل قسم جلسات الإستماع في الولاية التابع لوزارة الشؤون الإجتماعية. لديك الحق بمراجعة المواد التي تشكل الوثائق المؤثرة على القرار و يمكنك الحصول على هذه الوثائق عن طريق الإتصال بوحدة الإستفسارات و الإجابة (على رقم الهاتف المذكور أعلاه). قد يتم تداول أي معلومات تقدمها مع برنامج الصحة النفسية ، و وزار تي الصحة و الصحة النفسية في الولاية ، و وزارة الصحة و الخدمات الإنسانية الفدرالية (المصدر: قانون سلطات و مؤسسات الضمان الإجتماعي، الفقرة 14100.2).

Distrito ng San Diego
Programa ng Pinagdalubhasaang Medi-Cal ng Kalusugang Kaisipan
PAUNANG-SABI NG PAG-GAWA
(Pagpahalaga)

Petsa: _____

Para kay: _____, Numero ng Medi-Cal: _____

Ang panukala ng kalusugang kaisipan para sa Distrito ng San Diego ay nagpasiya, pagkatapos suriin muli ang mga resulta ng pagpahalaga sa kalagayan ng iyong kalusugang kaisipan, na ang kalagayan ng iyong kalusugang kaisipan ay hindi nakasapat sa pamantayan na kinakailangan ng medikal na maging karpit-dapat mahirang para sa pinagdalubhasaang mga serbisyo ng kalusugang kaisipan sa pamagitan ng panukala.

Sa palagay ng panukala ng kalusugang kaisipan, ang kalagayan ng iyong kalusugang kaisipan ay hindi nakasapat ng pamantayan na kinakailangan ng medikal, na siyang napabilang sa pormal na mga pamahala sa Titulo 9, California Code of Regulations (CCR), Section 1830.205, sa dahilan ay tiyak sa ibaba:

- ☐ Ang pag-susuri ng iyong kalusugang kaisipan na kinikilala sa pagpahalaga ay hindi napabilang sa panukala ng kalusugang kaisipan (Title 9, CCR, Section 1830.205(b)(1)).
- ☐ Ang kalagayan ng iyong kalusugang kaisipan ay hindi dahilan ng mga problema para sa iyong araw-araw na pamumuhay na maging sapat na mahalaga para ikaw ay karpit-dapat mahirang para sa pinagdalubhasaang mga serbisyo ng kalusugang kaisipan na mula sa panukala ng kalusugang kaisipan (Title 9, CCR, Section 1830.205(b)(2)).
- ☐ Ang mga serbisyo ng pinagdalubhasaang kalusugang kaisipan na magagamit mula sa panukala ng kalusugang kaisipan ay hindi ka maaring matutulungan upang manatili o pagbutihin ang kalagayan ng iyong kalusugang kaisipan (Title 9, CCR, Section 1830.205(b)(3)(A) and (B)).
- ☐ Ang kalagayan ng iyong kalusugang kaisipan ay maaring sumang-ayon sa pag-gamot ng tagapag-alaga ng kalusugang pangkatawan (Title 9, CCR, 1830.205(b)(3)(C)).

Kung ikaw ay sang-ayon sa panukalang pasiya, at gustong magkaroon ng impormasyon tungkol kung paano makahanap ng tagapag-alaga sa labas ng iyong panukala na mag-gagamot sa iyo, ikaw ay maaring tumawag o kausapin ang representante ng iyong panukala ng kalusugang kaisipan sa (800) 479-3339 o sumulat sa: Utilization Management, Optum, P.O. Box 601370, San Diego, CA 92160-1370.

Kung ikaw ay hindi sang-ayon sa panukalang pasiya, ikaw ay maaring gumawa ng isa o mahigit pa sa mga sumusunod:

Ikaw ay maaring humiling sa panukala ng pangalawang opinyon tungkol sa iyong kalagayan ng kalusugang kaisipan. Sa pag-gawa nito, ikaw ay maaring tumawag o kausapin ang representante ng iyong panukala ng kalusugang kaisipan sa (800) 479-3339 o sumulat sa: Utilization Management, Optum, P.O. Box 601370, San Diego, CA 92160-1370.

Ikaw ay maaring magsampa ng panawagan sa iyong kalusugang kaisipan. Para sa mga serbisyo ng mga pasyenteng nasa ospital na tumatanggap ng tirahan at pagkain kasama na ang pag-gamot/naninirahan, ikaw ay maaring tumawag at makiusap o sumulat sa representante ng JFS Programa ng Tagapagtanggol ng Pasyente sa (800) 479-2233, 2710 Adams Avenue, San Diego, CA 92116. Para sa mga pasyenteng hindi na ospital at lahat ng iba pang mga serbisyo ng kaulusugang kaisipan, ikaw ay maaring tumawag at makiusap o sumulat sa representante ng Lugar para sa partikular na Gawain ng Mamimili para sa Edukasyon ng Kalusugan at Tagapagtanggol sa (877) 734-3258, 1764 San Diego Avenue, Ste 200, San Diego, CA 92110. O maaring sundin ang mga direksyon nasa impormasyon ng polyeto na ibinigay sa iyo ng kalusugang kaisipan. Ikaw ay dapat magsampa ng panawagan sa loob ng 90 na araw mula sa petsa nitong paunang-sabi. Karamihan sa mga kalagayan ang panukala ng kalusugang kaisipan ay dapat gumawa ng pasiya ng inyong panawagan sa loob ng 45 na araw ng iyong paghiling. Ikaw maaring humiling ng mapabilis na panawagan, na kailangang mapasiyahan sa loob ng 3 gumaganang mga araw, kung iyong pinapaniwala na pag-naatraso ay magiging dahilan ng malubhang mga problema ng iyong kalusugang kaisipan kasama ang mga problema ng iyong kakayanang makamit, mapanatili, o mabawi ang mga mahalagang takbo ng buhay.

Kung ikaw ay may katanongan tungkol nitong paunang-sabi, para sa mga serbisyo ng mga pasyenteng nasa ospital na tumatanggap ng tirahan at pagkain kasama na ang pag-gamot/naninirahan, ikaw ay maaring tumawag at makiusap o sumulat sa representante ng JFS Programa ng tagapagtanggol ng Pasyente sa (800) 479-2233, 2710 Adams Avenue, San Diego, CA 92116. Para sa mga pasyenteng hindi na ospital at lahat ng iba pang mga serbisyo ng kalusugang kaisipan, ikaw ay maaring tumawag at makiusap o sumulat sa representante ng Lugar para sa partikular na Gawain ng Mamimili para sa Edukasyon ng Kalusugan at Tagapagtanggol sa (877) 734-3258, 1764 San Diego Avenue, Ste 200, San Diego, CA 92110.

Kung ikaw ay hindi nasisiyahan sa resulta ng iyong panawagan, ikaw ay maaring humiling ng makatarungan na paghukom sa Estados. Sa kabila nitong porma ay nagpapaliwanag kung paano humiling ng paghukom.

ANG IYONG KARAPATAN SA PAGHUKOM

Ikaw ay maroong 90 na araw lamang para humiling ng paghukom. Ang 90 na araw ay magmula alinmang:

1. Ang araw pagkatapos naming pinansariling ibinigay sa iyo itong paunang saging pasiya ng panukala ng kalusugang kaisipang panawagan, O
2. Ang araw pagkatapos sa petsa ng tatak-koreo nitong paunang saging pasiya ng panukala ng kalusugang kaisipang panawagan.

Minamadaling Pormal Na Paghukom

Ito'y karaniwang umabot ng 90 na araw, mula sa petsa ng iyong kahilingan para magawa ang pasiya ng paghukom. Kung iyong iniisip na itong tiyempo ay maging dahilan ng malubhang mga problema ng iyong kalusugang kaisipan, kasama ang mga problema ng iyong kakayanang makamit, mapanatili o mabawala ng mga mahalagang takbo ng buhay, ikaw ay maaaring humiling ng pormal na minamadaling paghukom. **Upang humiling ng minamadaling paghukom, kung maaari ay tiyakin and unang kahon na nasa hanay ng kanang kamay nitong pahina sa ibaba ng KAHILANGAN NG PAGHUKOM at isama ang dahilan kung bakit ikaw ay humihiling ng minamadaling paghukom.** Kung ang minamadaling paghukom na iyong hinihiling ay pinahintulutan, ang pasiya ng paghukom ay mabibigay sa loob ng tatlong gumaganang mga araw sa petsa ng pagkatanggap ng iyong hinihiling ng Pangkat na Pormal ng Paghukom.

Upang Maitago ang Iyong mga Serbisyo na Walang Pagbabago Habang Ikaw ay Naghihintay ng Paghukom

- Ikaw ay dapat humiling ng paghukom sa loob ng 10 na araw mula sa petsa ng pagpadala ng paunang saging pasiya ng panukala ng kalusugang kaisipang panawagan o pribadong ibinigay sa iyo o bago sa petsang magkabisang pagpalit ng mga serbisyo, alinmang huli.
- Ang serbisyo ng iyong Medi-Cal ng kalusugang kaisipan ay manatiling walang pagbabago hanggang ang huling pasiya ng hukoman ay magagawa alinmang salungat sa iyo, iurong mo ang iyong kahilingan para sa paghukom, o sa oras ng panahon o ang takda ng serbisyo para sa iyong kasalukuyang mga serbisyo ay na walang bisa, alinmang unang naganap.

Pormal na mga Pamahalang Magagamit

Pormal na mga pamahala, kasama ang mga nakabilang na pormal na mga paghukom, ay magagamit sa iyong lokal na opisina ng distrito ng kabutihan.

Upang Makakuha ng Tulong

Ikaw ay maaaring makakuha ng libring tulong sa iyong lokal na opisina ng tulong ayon sa batas o ibang mga pangkat. Para sa mga problema ng mga serbisyo ng kalusugang kaisipan ng mga pasyenteng nasa ospital na tumatanggap ng tirahan at pagkain kasama na ang paggamot at sa naninirahan, tumawag sa JFS Programa ng Tagapagtanggol ng Pasyente sa 800-479-2233. Para sa mga problema ng mga pasyenteng hindi na ospital at sa lahat ng iba pang mga serbisyo ng kalusugang kaisipan, tumawag ng libring bayad sa Lugar para sa partikular na Gawain ng Mamimili para sa Edukasyon ng Kalusugan at Pasyente sa 877-734-3258. Ikaw ay maaring magtanong tungkol sa karapatan ng paghukom o libring tulong ayon sa batas na galling sa Pampublikong Pagtatanong at Pangkat ng Tumutugon:

Tumawag ng libring bayad: 1-800-952-5253

Kung ikaw ay bingi at gumagamit ng TDD, tumawag sa: 1-800-952-8349

Ang Maaaring maging Representante

Maaaring ikaw ang representante para sa iyong sarili sa pormal na paghukom. Maaaring din ikaw ay representante ng iyong kaibigan, maging ang abogado o kung sino man ang pipiliin mo. Ikaw mismo ang mag-areglo nitong magiging representante.

Inpormasyon ng Paunang sabi na Isinagawa ng Batas (California Civil Code Section 1798, et seq.) Ang inpormasyong tinatanong sa iyo na isusulat sa pormang ito ay kinakailangan upang magawa ng

hakbang ang iyong hinihiling sa hukom an. Maaring maatraso ang paggawa ng hakbang kung ang iyong inpormasyon ay hindi kompleto. Ang kaso na sinampa ay gagawin ng Pangkat ng Pormal na mga Paghukom sa Departamento ng mga Serbisyo ng Panlipunan. Ikaw ay may karapatang magsiyasat ng mga materyales na ginawa sa pagtala para sa pasiya at maaring mahanap itong pagtala ng makipag-alam sa Pampublikong Pagtatanong at Pangkat ng Tumutugon (ang numero ng telepono ay makikita sa itaas). Ano mang inpormasyon na iyong ibinigay ito ay maaring ibahagi sa panukala ng kalusugang kaisipan, sa Pormal na Departamento ng mga Serbisyo ng Kalusugang Kaisipan at kasama ang Estados Unidos Departamento ng Kalusugan at Makatang mga Serbisyo. (Kapangyarihan: Kodigo ng Kabutihan at Pagtatatag, Seksiyon 14100.2)

PAANO HUMILING NG PORMAL NA PAGHUKOM

Ang pinakamabuting paraan sa paghiling ng hukoman ay ang pagpuno nitong pahina. Gumawa ng kopya sa harapan at likuran para sa iyong mga tala. Pagkatapos ipadala itong pahina sa:

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

Ibang paraan sa paghiling ng hukoman ay ang pagtawag sa 1-800-952-5253. Kung ikaw ay bingi at gumagamit ng TDD, tumawag sa 1-800-952-8349.

KAHILANGAN NG PAGHUKOM

Gusto ko ng paghukom dahil sa kaugnayan ng paggawa ng Medi-Cal batay sa Kalusugang Kaisipan sa Distrito ng San Diego.

☐ Tiyakin dito kung gusto mo nang minamadaling pormal na paghukom at isama ang dahilan sa ibaba.

Ito ang dahilan: _____

☐ Tiyakin dito at magdagdag ng pahina kung kinakailangan mong magdagdag ng lugar.

Ang aking pangalan: (isulat ng palimbag) _____

Numero ng aking Sosyal Sekyuriti: _____

Ang aking tirahan: (isulat na palimbag) _____

Numero ng aking telepono: () _____

Ang aking pirma: _____

Petsa: _____

Kailangan ko ng tagapagligwanag na walang bayad sa akin. Ang aking lingguwahe o wikain ay: _____

Gusto ko ang taong nakapangalan sa ibaba na magrepresentante sa akin nitong paghukom. Ibibigay ko ang aking pahintulot nitong tao namakikita ang aking mga tala at darating sa hukoman para sa akin.

Pangalan: _____

Tirahan: _____

Numero ng telepono: () _____

SUS DERECHOS A TENER UNA AUDIENCIA

Sólo tiene 90 días para solicitar una audiencia. Los 90 días comienzan, ya sea:

1. El día después de que personalmente le entregamos este aviso de la decisión a la apelación de salud mental, **O**
2. El día después de la fecha en el matasellos de este aviso de la decisión a la apelación de salud mental.

Audiencias Expeditas del Estado

Generalmente tarda 90 días a partir de la fecha de su solicitud para tomar una decisión sobre la audiencia. Si piensa que esperar por ese período de tiempo podría ocasionar serios problemas a su salud mental, como problemas relacionados con su capacidad para adquirir, mantener o recuperar funciones vitales importantes, usted puede solicitar una audiencia expedita del estado. **Para solicitar una audiencia expedita, por favor marque la primera casilla en la columna del lado derecho de esta página, bajo el título SOLICITUD DE AUDIENCIA, e incluya la razón por la que está solicitando una audiencia expedita.** Si su solicitud para una audiencia expedita es aprobada, la decisión para la audiencia será emitida dentro de los tres días hábiles siguientes a la fecha en que la División de Audiencias del Estado (*State Hearings Division*) haya recibido su solicitud.

Para conservar los mismos servicios que está recibiendo mientras espera por la audiencia

- Usted debe solicitar la audiencia dentro de los 10 primeros días a partir de la fecha en que se le envió por correo la decisión del plan de salud mental o de la fecha en que se le entregó personalmente; o antes de la fecha efectiva del cambio de servicios, lo que ocurra después.
- Sus servicios de salud mental de Medi-Cal seguirán siendo los mismos hasta que en la audiencia se tome una decisión en contra suya, usted retire su solicitud para una audiencia, o el período de tiempo o los límites de servicio para sus servicios actuales expire, lo que suceda primero.

Reglamentos estatales disponibles

Los reglamentos estatales, incluyendo aquellos que cubren audiencias estatales, están a su disposición en la oficina local de prestaciones de bienestar social (*welfare*) del condado.

Para obtener ayuda

Usted puede obtener ayuda legal gratuita en su oficina local de asistencia legal o a través de otros grupos. Para problemas relacionados con servicios de salud mental residenciales o de pacientes hospitalizados, llame a l programa de call JFS Patient Advocacy Program at 800-479-2233. Para problemas con pacientes ambulatorios y para todos los otros servicios de salud mental llame al número de teléfono gratuito del Consumer Center for Health Education and Advocacy at 877-734-3258. Puede preguntar acerca de sus derechos de audiencia o sobre la asistencia legal gratuita del *Public Inquiry and Response Unit* (Unidad de Preguntas y Respuestas al Público):

Llame gratuitamente al: 1-800-952-5253

Si usted es sordo y usa la línea TDD, llame al: 1-800-952-8349

Representante autorizado

Usted puede representarse a sí mismo en la audiencia del estado. También puede ser representado por un amigo, un abogado o por cualquier persona que usted elija. Usted debe hacer los arreglos para que lo representen.

Aviso de la ley sobre prácticas de información (Sección 1798, et. seq. del Código Civil de California).

La información que se le pide que proporcione en este formulario es necesaria para procesar su solicitud de audiencia. El proceso puede retrasarse si la información no está completa. La División de Audiencias del Estado del Departamento de Servicios Sociales abrirá un expediente de su caso. Usted tiene derecho a examinar los materiales que componen el expediente para la decisión y puede localizar dicho expediente contactando a la Unidad de Preguntas y Respuestas al Público (a los números de teléfono anteriores). Cualquier información que usted proporcione podría ser compartida con el plan de salud mental, los Departamentos Estatales de Servicios de Salud y de Servicios de Salud Mental y con el Departamento de Servicios Humanos y de Salud de los Estados Unidos. (Autoridad: Sección 14100.2 del Código de Instituciones y Prestaciones de Bienestar Social.)

CÓMO SOLICITAR UNA AUDIENCIA DEL ESTADO

La mejor forma de solicitar una audiencia del estado es completando esta página. Saque una copia del frente y del reverso para conservar como constancia. Después envíe esta página a:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

Otra forma de solicitar una audiencia es llamando al 1-800-952-5253
Si usted es sordo y usa TDD, llame al 1-800-952-8349

SOLICITUD DE AUDIENCIA

Deseo una audiencia debido a la acción tomada por el Plan de Salud Mental del Condado de San Diego en relación con Medi-Cal.

☐ Marque aquí si desea una audiencia expedita del estado y explique la razón de su solicitud a continuación.

La razón por la que deseo una audiencia expedita es: _____

☐ Si necesita más espacio marque aquí y añada una página.

Mi nombre: (letra de imprenta) _____

Mi número de Seguro Social: _____

Mi domicilio: (letra de imprenta) _____

Mi número de teléfono: (_____) _____

Mi firma: _____

Fecha: _____

Necesito de los servicios de un intérprete sin costo para mí. Mi idioma o dialecto es: _____

Deseo que la persona nombrada a continuación me represente en esta audiencia. Autorizo a dicha persona a que vea mi expediente y a que acuda a la audiencia por mí.

Nombre _____

Domicilio _____

Número de teléfono: _____

QUYỀN ĐIỀU TRẦN

Quý vị chỉ có 90 ngày để yêu cầu buổi điều trần. 90 ngày bắt đầu:

1. Tính từ ngày chúng tôi đích thân đưa quý vị bản thông báo khiếu nại sức khỏe tâm thần này, HAY
2. Tính từ ngày dấu bưu điện in trên bản thông báo khiếu nại sức khỏe tâm thần này.

Buổi Điều trần Nhanh Chóng cấp Tiểu bang

Thường mất 90 ngày kể từ ngày quý vị yêu cầu. Nếu quý vị nghĩ thời gian này có thể gây nguy hại trầm trọng cho sức khỏe tâm thần của mình gồm việc duy trì và phục hồi các chức năng quan trọng của đời sống, quý vị có thể xin được xử nhanh hơn thường lệ. **Để có một buổi điều trần nhanh, xin vui lòng đánh dấu ô đầu tiên bên phải của trang này dưới chữ YÊU CẦU ĐIỀU TRẦN và ghi cả nguyên nhân yêu cầu được xử nhanh.** Nếu lời yêu cầu của quý vị được chấp nhận, người ta sẽ thông báo cho quý vị biết trong vòng ba ngày làm việc tính từ ngày Ủy Ban Điều Trần Tiểu bang nhận khiếu nại của quý vị.

Để được nhận cùng dịch vụ trong khi quý vị chờ đợi buổi Điều trần

- Quý vị phải yêu cầu có buổi điều trần trong vòng 10 ngày tính từ ngày bản thông báo khiếu nại sức khỏe tâm thần gửi đến hay được giao tận tay cho quý vị trước ngày thay đổi dịch vụ, tính theo việc nào xảy ra trễ hơn.
- Các dịch vụ sức khỏe tâm thần Medi-Cal sẽ vẫn giữ nguyên cho đến khi có quyết định cuối cùng của buổi điều trần và nếu kết quả bất lợi cho quý vị, và quý vị thu hồi lời yêu cầu, hay cho đến khi thời hạn nhận dịch vụ bị hết hạn, tính theo việc nào đến trước.

Các Luật Điều Hành Cấp Tiểu Bang

Luật điều hành tiểu bang, bao gồm tin tức điều trần đều có sẵn trong văn phòng trợ cấp xã hội của quận hạt địa phương.

Để được giúp đỡ

Quý vị có thể nhận được sự giúp đỡ pháp lý từ văn phòng trợ giúp pháp lý địa phương hay từ các nhóm khác. Về các vấn đề khó khăn với bệnh nhân nội trú hay các dịch vụ sức khỏe tâm thần tại gia, hãy gọi Chương trình Bệnh vực Bệnh nhân JFS ở số 800-479-2233. Về các vấn đề khó khăn với bệnh nhân ngoại viện và các dịch vụ sức khỏe tâm thần khác, hãy gọi số miễn phí đến Trung tâm Tiêu thụ Giáo dục Sức khỏe và Bệnh vực quyền lợi (Consumer Center for Health Education and Advocacy) ở số 877-734-3258. Quý vị có thể yêu cầu tin tức về quyền xin điều trần hay giúp đỡ pháp lý từ Public Inquiry and Response Unit:

Gọi số miễn phí : 1-800-952-5253

Nếu khiếm thính, gọi TDD, call: 1-800-952-8349

Người đại diện hợp pháp

Quý vị có thể tự điều trần trước phiên xử. Quý vị cũng có thể chọn một người bạn, một luật sư hay bất cứ ai đại diện cho mình. Quý vị phải tự mình sắp xếp việc này

Thông báo của Practices Act Notice (California Civil Code Section 1798, et seq.) Chi tiết mà quý vị được yêu cầu viết trong mẫu này rất cần thiết để xúc tiến buổi điều trần của quý vị. Việc xúc tiến có thể trễ nãi nếu chi tiết không đầy đủ. Hồ sơ sẽ được thiết lập bởi Bộ Xã Hội Tiểu bang, Bộ phận Điều trần. Quý vị có quyền tham khảo hồ sơ và biết nó ở đâu bằng cách liên lạc với Public Inquiry and Response Unit (điện thoại đã ghi bên trên). Bất

cứ chi tiết nào mà quý vị cung cấp, chúng tôi sẽ chia sẻ với chương trình sức khỏe tâm thần, với Bộ Dịch vụ Y tế và Sức Khỏe Tâm thần Tiểu bang và với Bộ Y tế và Nhân sinh của Liên bang (Authority: Welfare and Institutions Code, Section 14100.2)

CÁCH YÊU CẦU BUỔI ĐIỀU TRẦN CẤP TIỂU BANG

Cách hay nhất để yêu cầu được buổi điều trần là điền vào mẫu này. Làm bản sao phần trước và sau của mẫu này để lưu giữ vào hồ sơ của quý vị. Sau đó gửi trang này về:

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

Một cách khác để xin buổi điều trần là gọi điện thoại số 1-800-952-5253. Nếu quý vị bị khiếm thính thì dùng TDD, gọi số 1-800-952-8349.

YÊU CẦU ĐIỀU TRẦN

Tôi muốn có một buổi điều trần liên hệ đến Medi-Cal và Chương Trình Sức Khỏe Tâm Thần của Quận hạt San Diego.

☐ Đánh dấu trong ô này nếu quý vị muốn có một buổi điều trần nhanh chóng và viết nguyên nhân tại sao :.

Nguyên nhân:

☐ Đánh dấu vào ô này nếu muốn viết thêm một trang nữa.

Tên họ (chữ in) _____

Số An sinh xã hội: _____

Địa chỉ (chữ in) _____

Điện thoại: (_____) _____

Chữ ký: _____

Ngày tháng: _____

Tôi cần một thông dịch viên miễn phí. Ngôn ngữ gốc của tôi là _____

Tôi muốn người có tên dưới đây đại diện tôi trong buổi điều trần. Tôi cho phép người này xem hồ sơ của tôi và đến dự buổi điều trần cùng tôi.

Tên họ: _____

Địa chỉ: _____

Điện thoại: (_____) _____

Appendix G Quality Improvement Program



REASONS FOR RECOUPMENT
FOR FY 2011-2012

NON-HOSPITAL SERVICES

MEDICAL NECESSITY:

1. Documentation in the chart does not establish that the beneficiary has a diagnosis contained in California Code of Regulations, (CCR), title 9, chapter 11, section 1830.205(b)(1)(A-R).

CCR, title 9, chapter 11, section 1830.205(b)(1)(A-R); CCR, title 9, chapter 11, section 1810.345(a); CCR, title 9, chapter 11, section 1840.112(b)(1) and (4)

2. Documentation in the chart does not establish that, as a result of a mental disorder listed in CCR, title 9, chapter 11, section 1830.205(b)(1)(A-R), the beneficiary has, at least, one of the following impairments:

- A significant impairment in an important area of life functioning
- A probability of significant deterioration in an important area of life functioning
- A probability the child will not progress developmentally as individually appropriate
- For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate

CCR, title 9, chapter 11, section 1830.205(b)(2)(A – C); CCR, title 9, chapter 11, section 1830.210(a)(3)

3. Documentation in the chart does not establish that the focus of the proposed intervention is to address the condition identified in CCR, title 9, chapter 11, section 1830.205(b)(2)(A),(B),(C)-(see below):

- A significant impairment in an important area of life functioning
- A probability of significant deterioration in an important area of life functioning
- A probability the child will not progress developmentally as individually appropriate
- For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate

NOTE: EPSDT services may be directed toward the substance abuse disorders of EPSDT eligible children who meet the criteria for specialty mental health services under this agreement, if such treatment is consistent with the goals of the mental health treatment and services are not otherwise available.

CCR, title 9, chapter 11, section 1830.205(b)(3)(A); CCR, title 9, chapter 11, section 1840.112(b)(4)

REASONS FOR RECOUPMENT **FOR FY 2011-2012**

4. Documentation in the chart does not establish the expectation that the proposed intervention will do, at least, one of the following:
- Significantly diminish the impairment
 - Prevent significant deterioration in an important area of life functioning
 - Allow the child to progress developmentally as individually appropriate
 - For full-scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition

CCR, title 9, chapter 11, section 1830.205(b)(3)(B); CCR, title 9, chapter 11, section 1810.345(c)

CLIENT PLAN:

5. Initial client plan was not completed within time period specified in the MHP's documentation guidelines, or lacking MHP guidelines, within 60 days of intake unless there is documentation supporting the need for more time.

CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(5); MHP Contract, Exhibit A, Attachment 1, Appendix C

6. Client plan was not completed, at least, on an annual basis as specified in the MHP's documentation guidelines.

CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(5); MHP Contract, Exhibit A, Attachment 1, Appendix C

7. No documentation of client or legal guardian participation in the plan or written explanation of the client's refusal or unavailability to sign as required in the MHP Contract with the DMH.

CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(5); MHP Contract, Exhibit A, Attachment 1, Appendix C

8. For beneficiaries receiving Therapeutic Behavioral Services (TBS), no documentation of a plan for TBS.

CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(5); MHP Contract, Exhibit A, Attachment 1, Appendix C; DMH Letter No. 99-03, Pages 6-7

PROGRESS NOTES:

9. No progress note was found for service claimed.

CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(3); CCR, title 22, chapter 3, section 51458.1(a)(3); MHP Contract, Exhibit A, Attachment 1, Appendix C

10. The time claimed was greater than the time documented.

CCR, title 9, chapter 11, section 1810.440(c); CCR, title 22, chapter 3, section 51458.1(a)(3) and (4); CCR, title 22, chapter 3, section 51470(a); MHP Contract, Exhibit A, Attachment 1, Appendix C

REASONS FOR RECOUPMENT **FOR FY 2011-2012**

11. The progress note indicates that the service was provided while the beneficiary resided in a setting where the beneficiary was ineligible for Federal Financial Participation. (e.g. Institute for Mental Disease, jail, and other similar settings, or in a setting subject to lockouts per CCR, title 9, chapter 11.)

CCR, title 9, chapter 11, section 1840.312(g-h); CCR, title 9, chapter 11, sections 1840.360-1840.374; Code of Federal Regulations (CFR), title 42, sections 435.1008 – 435.1009; CFR, title 42, section 440.168; CCR, title 22, section 50273(a)(1-9); CCR, title 22, section 51458.1(a)(8); United States Code (USC), title 42, chapter 7, section 1396d

12. The progress note clearly indicates that the service was provided to a beneficiary in juvenile hall and when ineligible for Medi-Cal. (Dependent minor is Medi-Cal eligible. Delinquent minor is only Medi-Cal eligible after adjudication for release into community).

CFR, title 42, sections 435.1008 – 435.1009; CCR, title 22, section 50273(a)(1-9)

13. The progress note indicates that the service provided was solely for one of the following:

- a) Academic educational service
- b) Vocational service that has work or work training as its actual purpose
- c) Recreation
- d) Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors

CCR, title 9, chapter 11, section 1840.312(a-d); CCR, title 9, chapter 11, section 1810.247; CCR, title 22, chapter 3, section 51458.1(a)(5) and (7)

14. The claim for a group activity was not properly apportioned to all clients present.

CCR, title 9, chapter 11, section 1840.314(c); CCR, title 9, chapter 11, section 1840.316(b)(2)

15. The progress note does not contain the signature (or electronic equivalent) of the person providing the service.

MHP Contract, Exhibit A, Attachment 1, Appendix C

16. The progress note indicates the service provided was solely transportation.

CCR, title 9, chapter 11, section 1810.355(a)(2), CCR, title 9, chapter 11, section 1840.312(f); CCR, title 9, chapter 11, section 1810.247; CCR, title 9, chapter 11, section 1840.110(a)

17. The progress note indicates the service provided was solely clerical.

CCR, title 9, chapter 11, section 1840.312(f); CCR, title 9, chapter 11, section 1810.247; CCR, title 9, chapter 11, section 1840.110(a); CCR, title 9, chapter 11, section 1830.205(b)(3)

18. The progress note indicates the service provided was solely payee related.

CCR, title 9, chapter 11, sections 1840.312(f); CCR, title 9, chapter 11, section 1810.247; CCR, title 9, chapter 11, section 1840.110(a); CCR, title 9, chapter 11, section 1830.205(b)(3)

REASONS FOR RECOUPMENT **FOR FY 2011-2012**

19. No service provided: Missed appointment per DMH Letter No. 02-07

CCR, title 9, chapter 11, section 1840.112(b)(3); CCR, title 22, chapter 3, section 51470(a); DMH Letter No. 02-07

20. For beneficiaries receiving TBS, the TBS progress notes overall clearly indicate that TBS was provided solely for one of the following reasons:

- a) For the convenience of the family, caregivers, physician, or teacher
- b) To provide supervision or to ensure compliance with terms and conditions of probation
- c) To ensure the child's/youth's physical safety or the safety of others, e.g., suicide watch
- d) To address conditions that are not a part of the child's/youth's mental health condition

DMH Letter No. 99-03, Page 4

21. For beneficiaries receiving TBS, the progress note clearly indicates that TBS was provided to a beneficiary in a hospital mental health unit, psychiatric health facility, nursing facility, or crisis residential facility.

DMH Letter No. 99-03, Page 5

HOSPITAL SERVICES

MEDICAL NECESSITY:

22. Documentation in the chart does not establish that the beneficiary has a diagnosis contained in Section 1820.205(a)(1)(A-R).

CCR, title 9, chapter 11, section 1820.205(a)(1)(A-R)

23. Documentation in the chart does not establish that, as a result of a mental disorder listed in Section 1820.205(a)(1)(A-R), the beneficiary requires psychiatric inpatient hospital services for, at least, one of the following reasons:

- Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction
- Presence of symptoms or behaviors that prevent the beneficiary from providing for, or utilizing food, clothing or shelter
- Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health
- Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function
- Need for psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the beneficiary is in a psychiatric inpatient hospital
- Presence of either a serious adverse reaction to medications or the need for procedures/therapies that require continued psychiatric inpatient hospitalization

CCR, title 9, chapter 11, sections 1820.205(a)(2)(B) and 1820.205(b)

REASONS FOR RECOUPMENT
FOR FY 2011-2012

ADMINISTRATIVE DAY:

24. Documentation in the chart does not establish that the beneficiary previously met medical necessity for acute psychiatric inpatient hospital service during the current hospital stay.

CCR, title 9, chapter 11, sections 1820.220(j)(5) and 1820.225(d)(2)

25. Documentation in the chart does not establish that the hospital made the minimum number of contacts with the non-acute residential treatment facilities as evidenced by a lack of the following:

- a) The status of the placement option(s)
- b) The dates of the contacts, and
- c) The signature of the person making each contact.

CCR, title 9, chapter 11, sections 1820.220(j)(5) and 1820.225(d)(2)

CLIENT PLAN:

26. The beneficiary record does not contain a client plan.

CFR, title 42, section 456.180; CCR, title 9, chapter 11, section 1820.210

27. The client plan was not signed by a physician.

CFR, title 42, section 456.180; CCR, title 9, chapter 11, section 1820.210

| |
|--------------|
| OTHER |
|--------------|

28. A claim for a day when the beneficiary was not admitted to the hospital.

CCR, title 9, chapter 11, section 1840.320(b)(1)

APPEAL PROCESS
Medi-Cal/ QI Billing Summary Report
San Diego County Mental Health Services

BHS Quality Improvement has developed the following 2-level process for a provider who wishes to appeal a disallowed service(s) decision.

1. QI Specialist will mail the provider a formal written report outlining the results of their medical record review within 30 days of review completion.
2. Provider has 14 days from the date of the cover letter attached to the written report to request a first level appeal.
3. First level appeal must be in writing, specify which disallowed service(s) is being appealed, reason why, and include any supporting documentation from the medical record. Appeal should be marked “confidential” and mailed to QI Program Manager.
4. First level appeal decision will be made within 7 working days from receipt of appeal letter. Provider will be informed of this decision in writing.
5. Should provider disagree with first level decision, provider has 7 working days from receipt of written decision to request a second level appeal. Second level appeal must be in writing, specify which disallowed service(s) is being appealed from first level decision, and reason why. Appeal should be marked “confidential” and mailed to QI Director.
6. Second level appeal decision will be made within 7 working days from receipt of appeal letter. Provider will be informed of this decision in writing.

Mailing address for Quality Improvement:
County of San Diego
Behavioral Health Services
P.O. Box 85524 Mailstop P-531G
San Diego, CA 92186-5524

Any questions regarding this procedure may be directed to QI Program Manager at 619.563.2747

**QUALITY IMPROVEMENT – HHSA-MHS
ADULT/OLDER ADULT OUTPATIENT
MEDICATION MONITORING SCREENING TOOL**

*Q.I. Confidential
Information*

*Q.I. Confidential
Information*

Please complete all boxes on this form with legible writing or type

| | |
|-----------------|----------------------|
| Program: | Psychiatrist: |
| Client: | Review Date: |
| Case #: | Reviewer: |

| | CRITERIA | COMPLIANCE | | | COMMENTS |
|---|--|--------------------------|--------------------------|--------------------------|----------|
| | | YES | NO | N/A | |
| 1. | Medication rationale and dosage is consistent with community standards. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. | If labs were indicated, were they ordered, obtained, & acted upon. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. | Physical health conditions and treatment considered when prescribing psychiatric medication. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. | No more than 2 medications of each chemical class concurrently without a clearly documented rationale. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. | Adverse drug reactions and/or side effects treated and managed effectively. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. | A signed consent form evidences informed consent. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. | Documentation is in accordance with prescribed medication. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Documentation includes client's: | | | | |
| 8a. | Response to medication therapy. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8b. | Presence/absence of side effects. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8c. | Extent of client's adherence with the prescribed medication regime and relevant interventions. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8d. | Client's degree of knowledge regarding management of his/her medication(s). | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| TOTAL (Please total the YES/NO columns) <i>Please complete a McFloop form if there are any variances.</i> | | | | | |

QUALITY IMPROVEMENT – HHSA-CHILDREN’S MHS MEDICATION MONITORING SCREENING TOOL

Please complete all boxes on this form with legible writing or type.

| | |
|----------------------------------|---------------------|
| Program: | Review Date: |
| Client (first name only): | Case #: |
| Treating Psychiatrist: | |
| Reviewer: | |

PLEASE NOTE: ALL “NO” ANSWERS REQUIRE A MCFLOOP FORM.

| | CRITERIA | COMPLIANCE | | | COMMENTS |
|----|---|--------------------------|--------------------------|--------------------------|---|
| | | Yes | No | NA | |
| 1. | Were medication rationale and dosage consistent with standard of care in Child and Adolescent Psychiatric community? | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 2. | If Labs were indicated, were they ordered, obtained, & acted upon? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. | Were physical health conditions and treatment considered when prescribing psychiatric medication? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. | For each class of meds below please indicate whether there was clearly documented rationale for prescribing <u>more</u> than 1 medication in each category: | | | | “No” answer means that the rationale was not clearly documented <u>and</u> client is on more than 1 med. in that class. Put N/A if client doesn’t take this medication. |
| | a. Stimulants | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | b. Mood Stabilizer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | c. Antidepressants | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | d. Antipsychotics | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | e. Antiparkinsonian | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5 | Were Adverse Drug Reactions and/or Side Effects treated and managed effectively? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. | Was informed consent obtained, as evidenced by a signed consent form or ex-parte order? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. | Was the diagnosis in concordance with prescribed medication? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. | Did treating M.D. document: | | | | |
| | a. client’s response to medication therapy? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | b. the presence/absence of side effects? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | c. the extent of client’s compliance with the prescribed medication regime and relevant interventions? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | d. measures taken to educate client/parent in regard to medication management? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

Medication Monitoring Committee Minutes

| | | | |
|--|--|--|--|
| Program Name: | | Meeting Date: | |
| <input type="checkbox"/> Quarter 1 Jul 1 – Sep 30, 20____ | <input type="checkbox"/> Quarter 2 Oct 1 – Dec 31, 20____ | <input type="checkbox"/> Quarter 3 Jan 1 – Mar 31, 20____ | <input type="checkbox"/> Quarter 4 Apr 1 – Jun 30, 20____ |
| Screened by: <input type="checkbox"/> County Pharmacy <input type="checkbox"/> MM Committee | | | |

Committee Members

Print Name

Discipline

Sign Name

Chairperson

Members

| | | |
|--|--|--|
| | | |
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Description of Activities

_____ Total Number of records screened this quarter

_____ Total Number of variances identified

_____ Total Number of McFloops required _____ # Approved/Completed _____ # Outstanding
 (please note that one McFloop form can be completed for one or more variances on a MM Screening Tool)

Please note

The Medication monitoring Submission Form is due 15 days after the end of each quarter (e.g. for first quarter; July, Aug, Sept; report due by Oct. 15) and can be emailed.

Any McFloops that are disapproved must be faxed in.

Do not submit this form or the medication monitoring tools

Please email your Medication Monitoring Submission form to:
QIMatters.hhhsa@sdcounty.ca.gov
Or fax to: (619) 236-1953

Medication Monitoring Feedback Loop Form

(McFloop)

TO: _____
Treating Physician

FROM: **Medication Monitoring Committee**

RE: **Program Name** _____

Patient Name _____

Case # _____

Summary of Recommendations/Requests for Action:

Reviewer Signature & Discipline

Date

Response/ Action taken by Treating Physician to Committee
(Written documentation/proof must be provided within 2 weeks)

Physician Signature & Discipline

Date

Verification of Physician Response

☐ **Approved**

☐ **Disapproved** (Forwarded to Medical Director)

Reviewer Signature & Discipline

Date

Mental Health Services**QUARTERLY STATUS REPORT-NARRATIVE**due the 20th calendar day of the month via email: MHS-COTR.HHSA@sdcounty.ca.gov

For instructions please click on the RED Markers located at top of the column

1. GENERAL INFORMATION:

| | | | |
|---------------------|---------------------|----------------|--------------------------------|
| Contractor Name | County of San Diego | Program Type | ADULT |
| Program Name | Program Name | Provider Type | COUNTY |
| Contract Number | NA | Report Period | Quarter 1 (7/1/2011-9/30/2011) |
| Unit/SubUnit Number | Unit/Sub Unit | Date Submitted | Date |
| Submitted By | Program Manager | Contact Phone | |

2. PROGRAM DESCRIPTION:**3. ACTIVITIES & EVENTS****4. COMMUNITY OUTREACH /COLLABORATION WITH OTHER AGENCIES/EDUCATION REGARDING SERVICES:**

| | | | | |
|--------------------|--------|----------|-----|-------------|
| Target Population: | Venue: | # Hours: | 0.0 | # Contacts: |
| Target Population: | Venue: | # Hours: | 0.0 | # Contacts: |
| Target Population: | Venue: | # Hours: | 0.0 | # Contacts: |
| Target Population: | Venue: | # Hours: | 0.0 | # Contacts: |

OTHER INFORMATION

County of San Diego - Health and Human Services Agency

Mental Health Services

Quarterly STATUS REPORT-NARRATIVE 2

Due the 20th calendar day of the month via email: MHS-COTR.HHSA@sdcounty.ca.gov
for instructions place cursor over the RED Markers located at the top of the column

1. GENERAL INFORMATION:

| | | | |
|-----------------|---------------------|----------------|--------------------------------|
| Contractor Name | County of San Diego | Program Type | ADULT |
| Program Name | Program Name | Provider Type | COUNTY |
| Contract Number | NA | Report Period | Quarter 1 (7/1/2011-9/30/2011) |
| Unit | Unit/Sub Unit | Date Submitted | Date |
| Submitted By | Program Manager | Contact Phone | |

5. PROGRAMMATIC ISSUES AND ACTIONS INITIATED TO SOLVE OR MITIGATE THEM:

6. EMERGING ISSUES OR POTENTIAL PROBLEMS:

7. QUALITY IMPROVEMENT ACTIVITIES:

OTHER INFORMATION

County of San Diego - Health and Human Services Agency
QUARTERLY STATUS REPORT-DATA

1. GENERAL INFORMATION:

| | | | |
|-----------------|---------------------|----------------|--------------------------------|
| Contractor Name | County of San Diego | Program Type | ADULT |
| Program Name | Program Name | Provider Type | COUNTY |
| Contract Number | NA | Report Period | Quarter 1 (7/1/2011-9/30/2011) |
| Unit | Unit/Sub Unit | Date Submitted | Date |
| Submitted By | Program Manager | Contact Phone | |

2. SERVICE AND BILLING UNITS:

| SERVICE FUNCTIONS | Service Units | | | | Billing Units | | | |
|--------------------------------|--------------------|--------------------------|---------------|-------------------|--------------------|--------------------------|---------------|----------------|
| | Annual Budgeted | Report Quarter Actual | YTD Actual | % obj complete | Annual Budgeted | Report Quarter Actual | YTD Actual | % obj complete |
| MHS | 0 | 0 | 0 | | 0 | 0 | 0 | |
| MED SUPPORT | 0 | 0 | 0 | | 0 | 0 | 0 | |
| CRISIS INTERVENTION | 0 | 0 | 0 | | 0 | 0 | 0 | |
| CM BROKERAGE | 0 | 0 | 0 | | 0 | 0 | 0 | |
| MAA | 0 | 0 | 0 | | 0 | 0 | 0 | |
| LIHP | 0 | 0 | 0 | | 0 | 0 | 0 | |
| Non LIHP | 0 | 0 | 0 | | 0 | 0 | 0 | |
| | | | | | | | | |
| SUB TOTAL BILLABLE | 0 | 0 | 0 | | 0 | 0 | 0 | |
| Non-BILLABLE SERVICES | | 0 | 0 | | | 0 | 0 | |
| Non-MAA | | 0 | 0 | | | 0 | 0 | |
| TOTAL of budgeted units | 0 | 0 | 0 | | 0 | 0 | 0 | |
| Percent of Year Elapsed | | | | | | | | 25% |
| COMMENTS | | | | | | | | |

3. STATISTICAL INFORMATION:

| | | |
|--|----------------|--------------|
| Total number count as of last calendar day of report month from ADC Quarter Report | Report Quarter | Year to Date |
| Admissions (ADC = Opened) | 0 | 0 |
| Discharges (ADC = Closed) | 0 | 0 |
| Active cases (ADC = End Load) | 0 | 0 |
| Unduplicated clients - (ADC = Unique Clients Served) | 0 | 0 |
| Unduplicated Clients LIHP (ADC Unique Clients Served) | 0 | 0 |
| Unduplicated LIHP Receiving Non LIHP Services (Tracked by Program) | 0 | 0 |
| Incident Report | 0 | 0 |
| Budgeted FTE Direct Service Staff (excluding consultants) | 0.00 | |
| Actual FTE Direct Service Staff | 0.00 | |
| Average Caseload per Actual Direct Service Staff FTE - #active cases/#direct service | | |

County of San Diego - Health and Human Services Agency

QUARTERLY STATUS REPORT-STAFFING AND PERSONNEL

1. GENERAL INFORMATION:

| | | | |
|----------------------|---------------------|----------------|--------------------------------|
| Contractor Name | County of San Diego | Program Type | ADULT |
| Program Name | Program Name | Provider Type | COUNTY |
| Contract Number | NA | Report Period | Quarter 1 (7/1/2011-9/30/2011) |
| Unit/Sub Unit Number | Unit/Sub Unit | Date Submitted | Date |
| Submitted By | Program Manager | Contact Phone | |

2. STAFFING UPDATES

☐ NONE (No Staffing Updates were generated this reporting period.)

3. PERSONNEL LISTING

[illegible]

| |
|--------------------|
| Volunteers/Interns |
|--------------------|

[illegible]

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[illegible][illegible]

| TERMINATED STAFF | |
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[illegible]

County of San Diego

Instructions to Monthly Status Report Staffing and Personnel Revised

The following instructions refer to section 3, "Personnel Listing," of the S&P-revised tab on the Monthly Status Report

| | |
|--|----------|
| Position Enter the full title of the employee's position. For example: | |
| •Director | •Analyst |
| •Clerk | •Student |
| •Secretary | •Intern |
| •Volunteer | |

| |
|---|
| Name Enter employee's First and Last Name |
|---|

| | | | | |
|--|-------|--------|-------|------|
| Credential Enter employee's credential/degree. If the employee is not credentialed, leave blank. | | | | |
| •M.D | •LCSW | •CSW | •Ph.D | •DAC |
| •D.O. | •LMFT | •R.N. | •Ed.D | •BCD |
| •MFT | •MFCC | •M.H.N | •LPC | |
| •LMSW | •ACSW | •Psy.D | •LMHC | |

| |
|--|
| Position Type Use one of the following categories when completing the Monthly Staffing and Personnel Report: |
| •A: Administration/Management- Managers & Analysts |
| •D: Direct Services- Psychiatrists, Psychologists, Clinicians, Social Workers, or Interns |
| •S: Support Services- Clerican and Case Aides |
| •V: Volunteers and/or Student Workers |

| |
|---|
| Budgeted Direct FTE Take Budgeted Direct FTE listing from contract documents, Schedules I & II. For interns, volunteers, or student workers, indicate paid/nonpaid status and hours worked (0.01 to 1.00) |
|---|

| |
|---|
| Budgeted Admin FTE Take Budgeted Admin FTE listing from contract documents, Schedules I & II. For interns, volunteers, or student workers, indicate paid/nonpaid status and hours worked (0.01 to 1.00) |
|---|

| |
|--|
| Actual Direct FTE Enter the actual Full Time Equivalent Direct Services employment for the employee during the report period. (0.01 to 1.00) |
|--|

| |
|---|
| Actual Admin FTE Enter Indirect Services employment for the employee during the report period. (0.01 to 1.00) |
|---|

| | |
|--|--------------------------|
| Ethnicity Code Enter the employee's Ethnicity code, choose from the following: | |
| •A: White | •R: Hmong |
| •B: African American | •S: Cuban |
| •C: American Indian | •T: Dominican |
| •D: Mexican American | •U: Salvadoran |
| •E: Other Latin America | •V: Sudanese |
| •F: Puerto Rican | •W: Ethiopian |
| •G: Chinese | •X: Somali |
| •H: Vietnamese | •Y: Iranian |
| •I: Laotian | •Z: Iraqi |
| •J: Cambodian | •1: Ameriasian |
| •K: Japanese | •2: Samoan |
| •L: Filipino | •3: Asian Indian |
| •M: Other Asian | •4: Hawaiian Native |
| •N: Other | •5: Guamanian |
| •O: Unknown | •6: Other Middle Eastern |
| •P: Pacific Islander | •7: Unknown/Not |
| •Q: Korean | Reported |

| | |
|--|---------------------------|
| Read & Write Proficiency Enter one (1) language code per column the individual reads or writes in, other than English. IF more than 4 languages, enter additional codes in LAST column. | |
| •A: English | •S: Armenian |
| •B: Spanish | •T: Ilocano |
| •C: Tagalog | •U: Mien |
| •D: Japanese | •V: Turkish |
| •E: Arabic | •W: Hebrew |
| •F: Vietnamese | •X: French |
| •G: Laotian | •Y: Polish |
| •H: Cambodian | •Z: Russian |
| •I: Sign Language | •1: Portuguese |
| •J: Other | •2: Italian |
| •K: Korean | •3: Samoan |
| •L: Mandarin Chinese | •4: Thai |
| •M: Cantonese Chinese | •5: German |
| •N: Other Chinese | •6: None (no reading/ |
| •O: Hmong | writing proficiency |
| •P: Farsi | •7: Ethiopian |
| •Q: Other Filipino Dialect | •8: Unknown/ Not reported |
| •R: Other Sign Language | |

| | |
|--|--|
| Specialty Code Enter the appropriate code (1 per column) for each staff whose education, experience, and training may qualify them to provide culturally competent services working with the specialty populations listed below. IF more than 9 codes, enter additional codes in LAST column. NOTE: The Specialty code was added in the right hand column on the modified Cultural Competency form. | |
| •A: Homeless | •I: Middle Eastern |
| •B: Adult Sexual Orientation (Gay/ Lesbian/Bisexual/ Transgender | •J: American Indian |
| •C: Older Adult | •K: Transition Age Youth |
| •D: African American | •L: Children Under the Age of Six |
| •E: Northeast African Refugee | •M: Youth Gay/ Lesbian/ Transgender |
| •F: Eastern European | •N: Juvenile Court Dependents |
| •G: Hispanic/Latino | •O: Juvenile Court Wards |
| •H: Southeast Asian | •P: Self-report of personal lived experience w/ mental illness |

| | |
|---|--|
| Hire Date Enter the actual Hire Date for each respective staff member hired by the program. Date format: mm/dd/yy | Term Date Enter the actual Termination Date for the employee. If the employee is still employed by the program, leave blank. |
|---|--|

| |
|---|
| Cultural Competency Training Completed Enter "Y" if the employee has completed 4 hours of Cultural Competency Training. Enter "N" if the employee has attended partial or no training. NOTE: Employees must attend Cultural Competency Training annually. |
|---|

| |
|--|
| Disaster Training Completed Enter "Y" if the employee has completed Disaster Training. Enter "N" if the employee has attended partial or no training. NOTE: Employees must attend Cultural Competency Training annually. |
|--|

| |
|--|
| Cultural Competency/Disaster Training Attended Enter the Training Course Designation, which corresponds to the course(s) attended by the employee. NOTE: The Training Course Designation can be acquired from the Training Report, leftmost column. |
|--|

| | | | |
|---|----------------------------|----------------|--|
| Language Proficiency Enter one (1) language code per column the individual speaks fluently from the following. IF there are more than 4 languages enter additional codes in LAST column. | | | |
| •A: English | •J: Other | •S: Armenian | •2: Italian |
| •B: Spanish | •K: Korean | •T: Ilocano | •3: Samoan |
| •C: Tagalog | •L: Mandarin Chinese | •U: Mien | •4: Thai |
| •D: Japanese | •M: Cantonese Chinese | •V: Turkish | •5: German |
| •E: Arabic | •N: Other Chinese | •W: Hebrew | •6: None (no reading/writing proficiency |
| •F: Vietnamese | •O: Hmong | •X: French | •7: Ethiopian |
| •G: Laotian | •P: Farsi | •Y: Polish | •8: Unknown/ Not reported |
| •H: Cambodian | •Q: Other Filipino Dialect | •Z: Russian | |
| •I: Sign Language | •R: Other Sign Language | •1: Portuguese | |

| |
|--|
| Terminated Staff When a staff person is terminated from the program, please transfer their information to the "Terminated Staff" section at the bottom of the page leaving the position information open until filled. |
|--|

Mental Health Services**QUARTERLY STATUS REPORT-SUGGESTIONS and TRANSFERS**

Due the 20th calendar day of the month via email: MHS-COTR.HHSA@sdcounty.ca.gov
 for instructions place cursor over the RED Markers located at the top of each column

1. GENERAL INFORMATION:

| | | | |
|-----------------|---------------------|----------------|--------------------------------|
| Contractor Name | County of San Diego | Program Type | ADULT |
| Program Name | Program Name | Provider Type | COUNTY |
| Contract Number | NA | Report Period | Quarter 1 (7/1/2011-9/30/2011) |
| Unit | Unit/Sub Unit | Date Submitted | Date |
| Submitted By | Program Manager | Contact Phone | |

2. Suggestion and Transfer Data

☒ **NONE (No Suggestion or Transfer Requests were received this reporting period.)**

| Date Received or Initiated mm/dd/yy | Indicate if this is Client (S) Suggestion or (T) Transfer Request | Client Suggestion Code 1-15 | Transfer Request Code 1-11 | Indicate if Client Transfer Request is (O) Out of Program or (N) To New Provider within the Program | Description of Client Suggestion or Transfer Request | Date of Resolution mm/dd/yy | Describe Resolution or Action Taken |
|--|---|--------------------------------------|-------------------------------------|--|---|-----------------------------------|---|
| | | | | | | | |
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Mental Health Services**QUARTERLY STATUS REPORT-NOTICE OF ACTION**

Due the 20th calendar day of the month via email: MHS-COTR.HHSA@sdcounty.ca.gov
 for instructions place cursor over the RED Markers located at the top of each column

1. GENERAL INFORMATION:

| | | | |
|-----------------|---------------------|----------------|--------------------------------|
| Contractor Name | County of San Diego | Program Type | ADULT |
| Program Name | Program Name | Provider Type | COUNTY |
| Contract Number | NA | Report Period | Quarter 1 (7/1/2011-9/30/2011) |
| Unit | Unit/Sub Unit | Date Submitted | Date |
| Submitted By | Program Manager | Contact Phone | |

2. Notice of Action - Assessment (NOA-A)
☒ NONE (No Notice of Action-A was issued this report month.)

| Date | ID Number | Client Response |
|------|-----------|-----------------|
| | | |
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3. Notice of Action - Denial of Service (NOA-B)
☒ NONE (No Notice of Action-B was issued this report month.)

| Date | ID Number | Client Response |
|------|-----------|-----------------|
| | | |
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| PATH GRANT DATA - Quarterly Demographic ROLLUP | | | | | | |
|--|---|-----|----|----|----|----|
| B. PERSONS SERVED | | | | | | |
| | | YTD | Q1 | Q2 | Q3 | Q4 |
| B1 | Persons who are homeless and have serious mental illnesses served by PATH funds and other sources. | 0 | | | | |
| B2a | Persons served by PATH funds via OUTREACH | 0 | 0 | 0 | 0 | 0 |
| B2b | Number of OUTREACH contacts who became enrolled in PATH during the year. | 0 | | | | |
| B2c | Number of OUTREACH contacts who did not become enrolled in PATH (B2a - B2b) | 0 | 0 | 0 | 0 | 0 |
| B2d | Number Not Enrolled due to Ineligibility (Subset of B2c) | 0 | | | | |
| | Number Eligible But Not Enrolled | 0 | 0 | 0 | 0 | 0 |
| B3 | <u>TOTAL</u> Persons Served (Enrolled) by PATH (Via outreach, referrals, walk-ins, etc) | 0 | | | | |
| B4 | Total Number of Persons Receiving and PATH Supported Service (this includes those not enrolled) | 0 | 0 | 0 | 0 | 0 |
| C. SERVICES PROVIDED | | | | | | |
| | | YTD | Q1 | Q2 | Q3 | Q4 |
| | <u>Number of Unduplicated Clients Who Received any of the Following Services in the Report Month</u> | 0 | 0 | 0 | 0 | 0 |
| Ca | Outreach (Ca) | 0 | | | | |
| Cb | Screening & Dx (Cb) | 0 | | | | |
| Cc | Habilitation/Rehab (Cc) | 0 | | | | |
| Cd | Mental Health Services (Cd) | 0 | | | | |
| Ce | Substance Abuse Tx (Ce) | 0 | | | | |
| Cg | Case Management (Cg) | 0 | | | | |
| Ch | Suppt/Suprv in Residential Setting (Ch) | 0 | | | | |
| Ci | Referral: 1° Health, Educ, Job Training, Housing (Ci) | 0 | | | | |
| Cj4 | Housing: Tech asst in Applying (Cj4). | 0 | | | | |
| Table C Outcomes | | | | | | |
| | OUTCOME MEASURES | YTD | Q1 | Q2 | Q3 | Q4 |
| | ASSISTED REFERRAL | 0 | 0 | 0 | 0 | 0 |
| Ck1 | Housing (transitional, supportive, permanent) | 0 | | | | |
| Ck2 | Income Benefits (SSI, SSDI, GR, etc) | 0 | | | | |
| Ck3 | Earned Income (Employment) | 0 | | | | |
| Ck4 | Medical Insurance (MediCal, Medicare, etc.) | 0 | | | | |
| Ck5 | Primary Medical Care (Physical Health Care) | 0 | | | | |
| | | | | | | |
| O U T C O M E S | ATTAINED | 0 | 0 | 0 | 0 | 0 |
| | Housing (transitional, supportive, permanent) | 0 | | | | |
| | Income Benefits (SSI, SSDI, GR, etc) | 0 | | | | |
| | Earned Income (Employment) | 0 | | | | |
| | Medical Insurance (MediCal, Medicare, etc.) | 0 | | | | |
| | Primary Medical Care (Physical Health Care) | 0 | | | | |
| D. DEMOGRAPHICS | | | | | | |
| D1 | <u>Age</u> | YTD | Q1 | Q2 | Q3 | Q4 |
| | | 0 | 0 | 0 | 0 | 0 |
| | 18-34 | 0 | | | | |
| | 35-49 | 0 | | | | |
| | 50-64 | 0 | | | | |
| | 65-74 | 0 | | | | |
| | 75+ | 0 | | | | |
| | Unknown | 0 | | | | |
| | | | | | | |
| | <u>Gender</u> | YTD | Q1 | Q2 | Q3 | Q4 |
| | | 0 | 0 | 0 | 0 | 0 |

| PATH GRANT DATA - Quarterly Demographic ROLLUP | | | | | | |
|--|--|-----|----|----|----|----|
| D2 | M | 0 | | | | |
| | F | 0 | | | | |
| | Unknown | 0 | | | | |
| D3 | <u>Race/Ethnicity</u> | YTD | Q1 | Q2 | Q3 | Q4 |
| | | 0 | 0 | 0 | 0 | 0 |
| | American Indian/Alaskan | 0 | | | | |
| | Asian | 0 | | | | |
| | Black | 0 | | | | |
| | Hispanic | 0 | | | | |
| | Hawaiian/Pacific Islander | 0 | | | | |
| | White | 0 | | | | |
| | Other | 0 | | | | |
| | Unknown | 0 | | | | |
| D4 | <u>Principal Mental Illness Diagnosis</u> | YTD | Q1 | Q2 | Q3 | Q4 |
| | | 0 | 0 | 0 | 0 | 0 |
| | Schizophrenia & Schizophreniform | 0 | | | | |
| | Schizoaff., Psychosis NOS & Delusional D/O | 0 | | | | |
| | Affective Disorders: PTSD, Mood, Anxiety, Bi-Polar | 0 | | | | |
| | Personality Disorders | 0 | | | | |
| | Other Mental Illness: somatoform, disassociative, etc. | 0 | | | | |
| | Unknown or undiagnosed Mental Illness | 0 | | | | |
| D5 | <u>Co-occurring Substance Abuse Disorders</u> | YTD | Q1 | Q2 | Q3 | Q4 |
| | | 0 | 0 | 0 | 0 | 0 |
| | Co-Occurring Substance Abuse Disorders | 0 | | | | |
| | No Co-Occurring Substance Abuse Disorders | 0 | | | | |
| | Unknown if Substance Abuse Disorders | 0 | | | | |
| D6 | <u>Veteran Status</u> | YTD | Q1 | Q2 | Q3 | Q4 |
| | | 0 | 0 | 0 | 0 | 0 |
| | Vet | 0 | | | | |
| | Non-Vet | 0 | | | | |
| | Unknown | 0 | | | | |
| D7 | <u>Housing Status at Intake</u> | YTD | Q1 | Q2 | Q3 | Q4 |
| | | 0 | 0 | 0 | 0 | 0 |
| | Outdoors | 0 | | | | |
| | Shelter or other temporary housing | 0 | | | | |
| | Long term shelter | 0 | | | | |
| | Own or someone else's apt, room or house | 0 | | | | |
| | Hotel, SRO, boarding house | 0 | | | | |
| | Halfway house, residential tx, sober living | 0 | | | | |
| | Institution | 0 | | | | |
| | Jail or other correctional facility | 0 | | | | |
| | Other | 0 | | | | |
| | Unknown | 0 | | | | |
| D8 | <u>Time Homeless (days) (on the street or short term shelter only)</u> | YTD | Q1 | Q2 | Q3 | Q4 |
| | | 0 | 0 | 0 | 0 | 0 |
| | 2 | 0 | | | | |
| | <30 | 0 | | | | |
| | 31-90 | 0 | | | | |
| | 91-365 | 0 | | | | |
| | 365+ | 0 | | | | |
| | Unknown | 0 | | | | |
| | <u>Further Information</u> | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Definitions

| | |
|--------------------------------------|---|
| Alcohol or Drug Treatment Services | Preventive, diagnostic, and other outpatient treatment services as well as support for people who have a psychological and/or physical dependence on one or more addictive substances, and a co-occurring mental illness. |
| Assisted Referral | <p>A referral that results in the completion and filing of a consumer's application for a service. An assisted referral would include the following activities being conducted by the program on behalf of or in conjunction with the consumer (if some, but not all, of these activities were conducted it does not count as a complete assisted referral):</p> <ul style="list-style-type: none"> * Assisting the consumer in obtaining the application, AND * Assisting the consumer in obtaining the appropriate supporting documentation, AND * Assisting the consumer with completion of the application, AND * Assisting the consumer in filing the application with the appropriate agency or organization (business if employment) * OR Referral to a program that specializes in assisting consumers with an application process and who can provide certification that the application has been successfully filed by the consumer. |
| Attainment | The PATH Provider confirms that the client attained the indicated service through client self-report or confirmation by other providers. A client is counted as attaining a service when they begin receiving the service. The client is not counted as attaining a service when the application process for a service is complete. PATH Providers are not required to obtain written documentation from another provider to confirm attainment. |
| Case Management Services | Services that develop case plans for delivering community services to PATH eligible recipients. The case plans should be developed in partnership with people who receive PATH services to coordinate evaluation, treatment, housing and/or care of individuals, tailored to individual needs and preferences. Case managers assist the individual in accessing needed services, coordinate the delivery of services in accordance with the case plan, and follow-up and monitor progress. Activities may include financial planning, access to entitlement assistance, representative payee services, etc. |
| Community Mental Health Services | Community-based supports designed to stabilize and provide ongoing supports and services for individuals with mental illnesses/co-occurring disorders or dual diagnoses. This general category does not include case management, alcohol or drug treatment and/or habilitation and rehabilitation, since they are defined separately in this document. |
| Co-Occurring Substance Use Disorders | Individuals experiencing substance use disorders only are not eligible for PATH services. However, PATH Providers are expected to serve individuals with co-occurring substance use disorders and provide documentation of this in the PATH Annual Report. The designation of a co-occurring disorder would occur when the worker, and in some cases the consumer, believes that the consumer is in a period of active use that affects his/her functioning or recovery from substance use and continues to require support. This definition does not require the consumer to be in treatment. Providers are encouraged to engage in a dialogue with the consumer to gain consensus on this determination. |
| Earned income | See employment |
| Eligibility | Once an individual is determined to meet the homeless or at risk of homelessness criteria and the mental health or co-occurring criteria, they are determined to be PATH eligible. |
| Enrollment | <p>PATH Enrollment implies that there is the intent to provide services for an individual other than those provided in the outreach setting. The term enrolled means that there is a mutual intent for the services to begin. PATH Enrollment is when:</p> <ol style="list-style-type: none"> 1) The individual has been determined to be PATH Eligible, 2) The individual and the PATH Provider have reached a point of engagement where there is a mutual agreement that "services" will be provided, and 3) The PATH Provider has started an individual file or record for the individual that includes at a minimum: <ol style="list-style-type: none"> a. Basic demographic information needed for reporting, b. Documentation by the Provider of the determination of PATH Eligibility, 2010 PATH Annual Reporting Guide 23 c. Documentation by the Provider of the mutual agreement for the provision of services, and |

| | |
|--|---|
| | <p>d. Documentation of services provided.</p> <p>Although the goal of the PATH program is to assist individuals in accessing mental health services and housing, services that begin the PATH enrolled relationship can be any service, assistance, or provision of resources that the individual is willing to accept or any mutual work that the individual identifies as important. PATH does not require that a service plan be developed unless case management services are part of the services provided to the individual. PATH Providers are expected to document all services and the outcomes in an individual file.</p> |
| Employment | Employment is any instance where services are performed that is subject to the will and control of an employer and for which wages are received by the worker. This definition of employment is not limited to full, part or seasonal employment, a minimum number of hours worked per week, or the availability of benefits. |
| Employment Services | Services designed to assist consumers with obtaining employment. Services may include, but are not limited to, application completion, resume development, interview training, and providing access to job listings. |
| Habilitation and Rehabilitation Services | Community-based treatment and education services designed to promote maximum functioning, a sense of well-being, and a personally satisfying level of independence for individuals who are homeless and have mental illnesses/co-occurring disorder. |
| Homeless Individual | According to the Public Health Services Act the definition of a homeless individual is an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing. |
| Housing Services | Specialized services designed to increase access to and maintenance of stable housing for individuals enrolled in PATH who have significant or unusual barriers to housing. For each enter the number of individuals enrolled in PATH who benefited from or received the service. These services are distinct from and not part of PATH funded case management, supportive and supervisory services in residential settings, or housing assistance referral activities. |
| Imminent Risk | Definitions of imminent risk for homelessness commonly include one or more of the following criteria: doubled-up living arrangement where the individual's name is not on the lease, living in a condemned building without a place to move, arrears in rent/utility payments, having received an eviction notice without a place to move, living in temporary or transitional housing that carries time limits, being discharged from a health care or criminal justice institution without a place to live. In addition to the criteria above, persons who live in substandard conditions are, by definition at risk of homelessness, due to local code enforcement, police action, voluntary action by the person, or inducements by service providers to go to alternatives like short-term shelters whose residents are considered to be homeless. There is not a recommended time-frame for imminence as individual state eviction laws vary in time and process. |
| Income Benefits | Income supports that are not earned income (wages), non-cash benefits (food stamps/Supplemental Nutrition Assistance Program (SNAP), etc), or temporary financial assistance (security deposits, rental assistance, utility or energy assistance). Income supports are financial supports that can be used at the consumer's discretion and are not limited to specific uses. Examples include Social Security Income (SSI), Social Security Disability Income (SSDI), Temporary Assistance for Needy Families (TANF), and pensions. |
| Literal Homelessness | Per the PATH legislation, "an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing. |
| Mainstream Services | Programs and resources that are available to consumers with an understanding that they will be able to remain available to the consumer after their transition out of homelessness. The PATH program encourages a focus on sustainable mental health services and housing. Other mainstream services of importance are services that provide health care, employment/vocational training, community connection, support, and resources for daily needs. |
| Medical Insurance Program | A program designed to provide medical insurance and/or medical co-pay assistance. |

| | |
|--|--|
| Outreach Services | <p>The process of bringing individuals who do not access traditional services into treatment. Effective outreach utilizes strategies aimed at engaging persons into the needed array of services, including identification of individuals in need, screening, development of rapport, offering support while assisting with immediate and basic needs, and referral to appropriate resources. Outreach results in increased access to and utilization of community services by people who are experiencing homelessness and mental illness.</p> <p>* Active outreach is defined as face-to-face interaction with literally homeless people in streets, shelters, under bridges, and in other non-traditional settings. In active outreach, workers seek out homeless individuals.</p> <p>* Outreach may include methods such as distribution of flyers and other written information, public service announcements, and other indirect methods.</p> <p>* Outreach may also include "inreach," defined as when outreach staff are placed in a service site frequented by homeless people, such as a shelter or community resource center, and direct, face to face interactions occur at that site. In this form of outreach, homeless individuals seek out outreach workers.</p> |
| Primary Medical Care | Medical care that is overseen by a licensed medical primary care provider. |
| Referrals for Primary Health Services, Job Training, Educational Services and Relevant Housing | Services intended to link persons to primary health care, job training, income supports, education, housing, and other needed services not directly provided by the PATH program or individual PATH Providers. |
| Serious Mental Illness: | <p>PATH Providers may determine individuals as meeting the Serious Mental Illness criteria if there is an informed presumption that the individual:</p> <p>* is experiencing or displaying symptoms of mental illness and is experiencing difficulty in functioning as a result of these symptoms that indicates severity, and</p> <p>* has shared or has a known history of engagement with mental health services OR has symptoms and functioning that indicates there is a history of or expected tenure of significant mental health concerns, and</p> <p>* is of appropriate age to be diagnosed with a Serious Mental Illness, where transition-age youth may be eligible. This determination should reflect and be consistent with the State's definition of Serious Mental Illness.</p> |
| Screening and Diagnostic | A continuum of assessment services that ranges from brief eligibility screening to comprehensive clinical assessment. |
| Technical assistance in Applying for Housing Assistance | Targeted training, guidance, information sharing, and assistance to, or on behalf of, individuals enrolled in PATH who encounter complex access issues related to housing. |
| Transition to Mainstream Services | Individuals enrolled in PATH make a formal change to housing and services funded through programs such as Section 8, Medicaid, public health, Mental Health/Substance Abuse, Block Grant, etc. |
| Youth | Transition age youth who are homeless or at-risk of homelessness, have a serious mental illness, and who are otherwise considered adults (e.g. emancipated youth, may be PATH Enrolled. Youth who are still eligible for other protective or human services may be served by PATH in the outreach setting, and when appropriate enrolled, for the sole purpose of engaging the human services agencies, mental health services, or the education system to serve them. The goal of PATH enrollment is to advocate for the youth in accessing the services available to them and prevent them from falling through the cracks. Serving youth who are minors solely in PATH without the purpose of rapidly, safely, and effectively connecting them to the mainstream child services system is not recommended for PATH programs. |

| PATH Eqv | PATH Services for Tracking | Anasazi ID | Anasazi Service Codes Available |
|-------------|---|---------------|---------------------------------|
| Ca | Outreach/Inreach | 65 | Community Services (non-MAA) |
| Cb | Screen/Dx | 5 | Screening Non-MAA |
| | | 9 | Assessment Psychosoc Interact |
| | | 10 | Assessment - Psychosocial |
| | | 12 | Psychological Testing |
| | | 16 | Psychological Test-Technician |
| Cc | Hab and Rehab | 13 | Plan Development |
| | | 30 | Psychotherapy-Individual |
| | | 31 | Psychotherapy - Group |
| | | 32 | Psychotherapy - Family |
| | | 33 | Collateral |
| | | 34 | Rehab - Individual |
| | | 35 | Rehab - Group |
| | | 36 | Rehab - Family |
| | | 37 | Rehab Evaluation |
| | | 38 | Pyschotherapy Interactive-Ind |
| | | 39 | Pyschotherapy Interactive-Grp |
| Cd | Comm. MH Services | 11 | Medication Evaluation |
| | | 14 | Eval of Records for Assessment |
| | | 20 | Medication Support Other |
| | | 21 | Medication Education Group |
| | | 23 | Med Check MD Brief |
| | | 70 | Crisis Intervention |
| Ce | AOD/COD Services | 22 | Meds - Pharmacological Mgmt |
| Cg | Case Management | 50 | Case Management / Brokerage |
| | | 55 | Case Mgmt Institutional Svc |
| | | 60 | Other Support non-billable |
| | | 63 | Substance Abuse Education |
| Ci | Referral to: Primary Care, Job Training, | 52 | PATH Referral-Special Service |
| Cj4 | Technical Assistance in Applying for Housing Assistance | 51 | PATH Section 8 Assistance |

Frequency of MORS Ratings:

| | | | | | | | Monthly Average |
|---------------------------|--|--|--|--|--|--|-----------------|
| Extreme risk | | | | | | | |
| High risk/not engaged | | | | | | | |
| High risk/engaged | | | | | | | |
| Poorly coping/not engaged | | | | | | | |
| Poorly coping/engaged | | | | | | | |
| Coping/rehabilitating | | | | | | | |
| Early Recovery | | | | | | | |
| Advanced Recovery | | | | | | | |

County of San Diego - Health and Human Services Agency
QUARTERLY STATUS REPORT-NOTICE OF ACTION A and B

1. General Information

| | | | |
|-----------------|---|----------------|---------------------------|
| Contractor Name | | Program Type | CHILD |
| Program Name | | Provider Type | CONTRACTOR |
| Contract Number | | Report Period | JULY 1-SEPTEMBER 30, 2011 |
| Unit | | Date Submitted | |
| SubUnit(s) | 0 | | |
| Submitted By | | Contact Phone | |

2. Notice of Action - Assessment (NOA-A)

☒ NONE (No Notice of Action-A was issued this reporting period.)

| Date | ID Number | Client Response |
|------|-----------|-----------------|
| | | |
| | | |
| | | |
| | | |
| | | |

3. Notice of Action - Denial of Service (NOA-B)

☒ NONE (No Notice of Action-B was issued this report month.)

| Date | ID Number | Client Response |
|------|-----------|-----------------|
| | | |
| | | |
| | | |
| | | |
| | | |

County of San Diego - Health and Human Services Agency

due the 15th calendar day of the month following each quarter via email:

MHS-COTR.HHSA@sdcounty.ca.gov; Tess.Widmayer@sdcounty.ca.gov; Angela.Hawley@sdcounty.ca.gov

QSR Naming Convention: Contractor name.Program name.Contract #.CQSR.Q# - year

Please write the QSR file name in the subject line of the email. If a revised MSR is sent, add "Revised.mm-dd-yy" after the QSR file name.
for instructions place cursor over the RED Markers located at the upper right corner of each heading.

1. GENERAL INFORMATION:

| | | | |
|-----------------|--|----------------|---------------------------|
| Contractor Name | | Program Type | CHILD |
| Program Name | | Provider Type | CONTRACTOR |
| Contract Number | | Report Period | JULY 1-SEPTEMBER 30, 2011 |
| Unit | | Date Submitted | |
| SubUnit(s) | | | |
| Submitted By | | Contact Phone | |

2. PROGRAM DESCRIPTION:

3. ACTIVITIES AND EVENTS:

4. COMMUNITY OUTREACH /COLLABORATION WITH OTHER AGENCIES/EDUCATION REGARDING SERVICES:

| | | | | | | |
|-------------------|--|-------|----------|--|---------------|--|
| Target Population | | Venue | # of Hrs | | # of Audience | |
| Target Population | | Venue | # of Hrs | | # of Audience | |
| Target Population | | Venue | # of Hrs | | # of Audience | |
| Target Population | | Venue | # of Hrs | | # of Audience | |

5. EMERGING ISSUES OR POTENTIAL PROBLEMS AND ACTIONS INITIATED TO SOLVE/ MITIGATE THEM

6. QUALITY IMPROVEMENT ACTIVITIES:

7. UTILIZATION MANAGEMENT ACTIVITIES (Year-to-Date) based on Unique Clients Services YTD

| | | | |
|--------------------------------|--|------|-----------------------|
| Over 13 (18) sessions (1st UM) | | 0.0% | Date of COTR Approval |
| Over 26 (36) sessions (2nd UM) | | 0.0% | |
| Over 39 sessions (3rd UM) | | 0.0% | |
| UM's Denied | | | |

Comments:

VLOOKUP DATE TABLE:
Report Period for cell I7

JULY 1-SEPTEMBER 30, 2011

OCTOBER 1-DECEMBER 31, 2011

JANUARY 1-MARCH 31, 2012

APRIL 1-JUNE 30, 2012

County of San Diego - Health and Human Services Agency
QUARTERLY STATUS REPORT-OUTCOMES

1. General Information

| | | | |
|-----------------|---|----------------|---------------------------|
| Contractor Name | | Program Type | CHILD |
| Program Name | | Provider Type | CONTRACTOR |
| Contract Number | | Report Period | JULY 1-SEPTEMBER 30, 2011 |
| Unit | | Date Submitted | |
| SubUnit(s) | 0 | | |
| Submitted By | | Contact Phone | |

7. OUTCOMES DATA:

| Number | Objectives | YTD Results | | |
|--------|---|-------------|--------|--|
| | | % | X of Y | |
| 1 | For 80% of discharged clients whose episode lasted 2 months or longer, the P-CAMS total score shall show improvement between Intake and Discharge CAMS. | | | |
| 2 | For 80% of discharged clients whose episode lasted 2 months or longer, the Y-CAMS total score shall show improvement between Intake and Discharge CAMS. | | | |
| 3 | For 80% of discharged clients whose episode lasted 3 weeks or longer, the CFARS score shall be at least one level lower (improvement) at Discharge than at Intake in at least one index area. | | | |
| 4 | For 80% of those clients whose episodes lasted 3 weeks or longer, the discharge summary shall reflect no increased impairment resulting from substance use , as measured by the domain rating for substance use. | | | |
| 5 | 90% of clients will avoid psychiatric hospitalization or re-hospitalization during the outpatient episode. | | | |
| 6 | At Discharge, 80% of clients whose episode lasted 2 months or longer, will have parent CAMS data available for both Intake and Discharge CAMS. | | | |
| 7 | At Discharge, 80% of clients whose episode lasted 2 months or longer, will have child CAMS data available for both Intake and Discharge CAMS. | | | |
| 8 | At Discharge, 100% of clients with an intake after September 1, 2007 and whose episode lasted 3 weeks or longer will have CFARS data available for both Intake and Discharge. | | | |

If there is a discrepancy between the numbers in the "Y" column and the number of Closed Cases (Discharges), please describe findings and mitigation.

| | | |
|---|-------|--|
| Contacted CASRC to resolve discrepancies on | Date: | |
| | | |

8. SCHOOL SITE LOCATIONS

***** ENTIRE PROGRAM *****

| Number | School Site (Year-to-Date) | School District | Hours/Week (as of the end of the report period) | # of Clients (as of the end of the report period) | # of groups held this QTR |
|--------|----------------------------|-----------------|---|---|---------------------------|
| | | | | | |
| | | | | | |
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| | | | | | |
| | | | | | |
| | | | | | |
| 0 | TOTAL SCHOOL SITE DATA | | | | |

County of San Diego - Health and Human Services Agency
QUARTERLY STATUS REPORT-DATA

1. GENERAL INFORMATION:

| | | | |
|-----------------|--|----------------|---------------------------|
| Contractor Name | | Program Type | CHILD |
| Program Name | | Provider Type | CONTRACTOR |
| Contract Number | | Report Period | JULY 1-SEPTEMBER 30, 2011 |
| Unit | | Date Submitted | |
| SubUnit(s) | | | |
| Submitted By | | Contact Phone | |

2. SERVICE AND BILLING UNITS:

Budgeted at %

| SERVICE FUNCTIONS | | | | | Billing Units | | | |
|---|---|--|--|--|--------------------|-------------------------|---------------|--------------|
| | | | | | Annual Budgeted | Report Period Actual | YTD Actual | % Elapsed |
| MHS | | | | | | | | |
| MHS-R | | | | | | | | |
| MHS-TBS | | | | | | | | |
| MED SUPPORT | | | | | | | | |
| CRISIS INTERVENTION | | | | | | | | |
| C.M. BROKERAGE | | | | | | | | |
| DAY TREATMENT INTENSIVE | | | | | | | | |
| DAY REHABILITATION | | | | | | | | |
| OTHER(SPECIFY) | | | | | | | | |
| TOTAL | | | | | 0 | 0 | 0 | |
| Percent of Year Elapsed | | | | | | | | 25% |
| Mitigation Plan if program is behind producing <u>billing minutes.</u> | | | | | | | | |
| Mitigation Plan if program is below <u>productivity standard.</u> | | | | | | | | |
| Actual program productivity | (YTD actual units)/ (total direct fte x 108,000 x % of year passed) | | | | | | | #DIV/0! |
| Estimated clinician productivity | (YTD actual MHS + CI units)/ (total clinician fte x 108,000 x % of year passed) | | | | | | | #DIV/0! |
| Estimated paraprofessional productivity | (YTD actual CM + MHS-R units)/ (total paraprofessional fte x 108,000 x % of year passed) | | | | | | | #DIV/0! |

3. STATISTICAL INFORMATION:

| | Target # | |
|---|---------------|--------------|
| Report Item (<i>total number count as of last calendar day of report month</i>) | Report Period | Year to Date |
| Cases Opened (Admissions) | | |
| Cases Closed (Discharges) | | |
| Ending Caseload (Active cases) | | |
| Unique Client Services (Unduplicated clients) | | 100 |
| Unusual Occurrence/Incident Report | | |
| Actual FTE Direct Service Staff | 0.00 | |
| Average Caseload per Actual Direct Service Staff FTE - <i>#active cases/#direct service</i> | #DIV/0! | |

4. FAMILIES PARTICIPATING IN PERSON AT LEAST ONCE PER MONTH (at the end of the report period)

| | | |
|------------------------------------|--|--------------------------|
| Total Number of Available Families | Total Number of Participating Families | Percent of Participation |
| | | |
| Comments: | | |

Vlookup table:

| <u>PERIOD</u> | <u>PERCENT</u> |
|-----------------------------|-------------------------|
| JULY 1-SEPTEMBER 30, 2011 | 25% |
| OCTOBER 1-DECEMBER 31, 2011 | 50% |
| JANUARY 1-MARCH 31, 2012 | 75% |
| APRIL 1-JUNE 30, 2012 | 100% |
| 25% | % of year passed |

County of San Diego - Health and Human Services Agency
QUARTERLY STATUS REPORT-STAFFING AND PERSONNEL

1. GENERAL INFORMATION:

| | | | |
|-----------------|---|----------------|----------------------|
| Contractor Name | | Program Type | CHILD |
| Program Name | | Provider Type | CONTRACTOR |
| Contract Number | | Report Period | JULY 1-SEPTEMBER 30, |
| Unit | | Date Submitted | |
| SubUnit(s) | 0 | | |
| Submitted By | | Contact Phone | |

2. STAFFING UPDATES

☒ **NONE (No Staffing Updates were generated this reporting period.)**
For each vacant position, note length of vacancy. If position is under-filled, please explain why.

3. PERSONNEL LISTING (as of the end of the reporting period)

[illegible]

4. TERMINATED STAFF

[illegible]

5. MONTHLY ACTUAL DIRECT FTE

| Month | Actual Direct FTE for Clinicians | Actual Direct FTE for Para-Professionals | Actual Direct FTE Other | Total Actual Direct FTE |
|---------------------|----------------------------------|--|-------------------------|-------------------------|
| JULY | | | | |
| AUGUST | | | | |
| SEPTEMBER | | | | |
| OCTOBER | | | | |
| NOVEMBER | | | | |
| DECEMBER | | | | |
| JANUARY | | | | |
| FEBRUARY | | | | |
| MARCH | | | | |
| APRIL | | | | |
| MAY | | | | |
| JUNE | | | | |
| AVERAGE FOR FY11-12 | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! |

County of San Diego - Health and Human Services Agency
QUARTERLY STATUS REPORT-SUGGESTION & TRANSFER

1. General Information

| | | | |
|-----------------|---|----------------|---------------------------|
| Contractor Name | | Program Type | CHILD |
| Program Name | | Provider Type | CONTRACTOR |
| Contract Number | | Report Period | JULY 1-SEPTEMBER 30, 2011 |
| Unit | | Date Submitted | |
| SubUnit(s) | 0 | | |
| Submitted By | | Contact Phone | |

2. Suggestion and Transfer Data (Year-to-Date)

☒ **NONE (No Suggestion or Transfer Requests were received.)**[illegible]

QUALITY IMPROVEMENT SERIOUS INCIDENT REPORT

*To be completed and submitted via FAX to Quality Improvement Department
within 72 hours of occurrence of incident*

| | | |
|--|--|---|
| Client Name: <input type="text"/> | | |
| Client Case Number: <input type="text"/> | DOB: <input type="text"/> | |
| Mental Health Diagnosis (Use DSM IV Codes) : Axis I (Primary) : <input type="text"/> Axis I (Secondary) : <input type="text"/> | | |
| Provider (Program) Name: <input type="text"/> | | |
| Parent Organization (if any): <input type="text"/> | | |
| Staff Involved: <input type="text"/> | | |
| Date of Incident: <input type="text"/> | Time of Incident: <input type="text"/> | Date reported to Provider: <input type="text"/> |
| Location where Incident Occurred: <input type="text"/> (Address/Setting) | | |
| Date and Time Incident was reported telephonically to BHS QI: <input type="text"/> | | |

1. Incident Reviewed (Please check one):

- ☐ Death, excluding natural causes – includes death by suicide
- ☐ Homicide by a client - attempted homicide by a client
- ☐ Suicide attempt resulting in severe physical damage and/or loss of consciousness, respiratory and/or circulatory difficulties requiring medical attention
- ☐ For mental health clients: use of physical restraints (prone or supine)*
- ☐ Adverse medication reaction resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.
- ☐ Medication error in prescription or distribution resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.
- ☐ Serious physical injury resulting in a client experiencing severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.
- ☐ Injurious assault on a client or by a client occurring on the program's premises resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.
- ☐ Inappropriate staff behavior such as sexual relations with a client, financial exploitation of a client, and/or physical or verbal abuse of a client.
- ☐ Major confidentiality breach (lost or stolen laptop, large number of client files/records accessed, etc.)
- ☐ Other:

CONFIDENTIAL

County of San Diego Behavioral Health Services

Client Name:

☐ **Notification to:** ☐ Parent ☐ CWS ☐ Probation ☐ Verbal ☐ Written

2. Describe the Serious Incident:

(Include people involved and precipitating factors. Indicate if client was admitted to acute care medical or psychiatric unit and length of stay, if known.)

(Continue on Page 3)

3. Other Behavioral Health Services Client is currently receiving:

(Outpatient, case management, medication management, day treatment/rehabilitation, residential, etc.)

(Continue on Page 3)

4. Current prescribed medication:

Name of prescribing physician:

5. Physical or medical concerns:

Report Completed By:

Date/Time:

Program Manager Signature:

Date/Time:

Contact Email:

Contact Phone:

Date Faxed to County QI:

CONFIDENTIAL
County of San Diego Behavioral Health Services

Client Name:

2. Describe the Serious Incident:

(Include people involved and precipitating factors. Indicate if client was admitted to acute care medical or psychiatric unit and length of stay, if known.)

(Continued from Page 2)

3. Other Behavioral Health Services Client is currently receiving:

(Outpatient, case management, medication management, day treatment/rehabilitation, residential, etc.)

(Continued from Page 2)

FAX #: (619) 236-1953
Quality ImprovementUnit

Serious Incident Report Line: (619) 563-2781

QUALITY IMPROVEMENT SERIOUS INCIDENT REPORT OF FINDINGS

*To be completed and submitted to Quality Improvement Department
within thirty (30) days of occurrence of incident*

Provider (Program) Name: Name of Client: Client Case Number: Date of Incident: RCA Required? ☐ YES ☐ NORCA Completed? ☐ YES ☐ NO**1. Summary of Findings:**

(Outline any clinical case conferences, meetings or investigations you conducted. Also attach copies of related newspaper articles, coroners and toxicology reports, etc.)

*Continued on Page 2***2. Post Committee Recommendations/Planned Improvements:***Continued on Page 2*Report Completed By: Date: Program Manager Signature: Date: Contact Email: Contact Phone: Date Faxed to County Quality Improvement:

CONFIDENTIAL

County of San Diego Behavioral Health Services

QUALITY IMPROVEMENT SERIOUS INCIDENT REPORT OF FINDINGS

3. Summary of Findings:

(Outline any clinical case conferences, meetings or investigations you conducted. Also attach copies of related newspaper articles, coroners and toxicology reports, etc.)

Continued from Page 2

4. Post Committee Recommendations/Planned Improvements:

Continued from Page 2

FAX #: (619) 236-1953
Quality ImprovementUnit

Serious Incident Report Line: (619) 563-2781

QUALITY IMPROVEMENT ACTIVITY

Directions for Root Cause Analysis (RCA)

The goal of the RCA is to identify systemic gaps or failures in systems and processes, not to point fingers or lay blame on individuals. The RCA is not the same as the investigation into the incident, which should be completed prior to the RCA.

Instructions for conducting the RCA:

A Root Cause Analysis (RCA) may be completed for any serious incidents, but must be completed for any incidents of suicide and any major loss of confidential client information.

The RCA worksheet that is attached will provide a structure for completing the RCA.

After identifying the Lead, Facilitator and the Participants of the RCA, schedule at least one meeting for the RCA group to complete the following tasks:

- 1) The first step in completing the worksheet for the RCA is describing the serious incident. Include who was involved, services that were effected, and other details of the incident. It is recommended that the incident being reviewed be written up a flow diagram as part of the process of describing the incident. A flow diagram is very useful in identifying gaps in systems and processes. Ask participants to come to the RCA meeting with a basic description of the incident from their perspective that includes dates and processes involved.
- 2) Next step is to note the participants in the RCA. Participants in the RCA may include those involved in the incident but must include those staff who are knowledgeable about the systems and processes that will be analyzed.
- 3) Next identify the systems and processes that will be analyzed. In general, systems and processes will be those programmatic issues that are defined by policy and procedures. Examples of systems and processes are noted in the worksheet. Not all systems and processes will apply in every case, and there may be others that are not listed on the worksheet that arise in the course of analysis.
- 4) The next step is to break down each system or process into the steps involved – it is helpful to have a workflow diagram for each system or process as this can assist in uncovering gaps.
- 5) Identify findings of gaps found in system or process design, how design of system or process compared to the real event, human factors, equipment factors, controllable environmental factors, and uncontrollable external factors. It can help to think about what the system or process would “ideally” look like even if the ideal does not seem possible.

QUALITY IMPROVEMENT ACTIVITY

6) Identify if the finding is a “root cause” (yes or no). For each finding of root cause an analysis is to be completed. Many findings that are not a root cause themselves have “roots” that may need to be addressed. Using a “fishbone” or Ishakawa diagram can assist in identifying these “hidden roots”.

7)The next step is to note if actions will be taken to address the issues that are identified as a root cause

8) The final element of the RCA is to note Action Plans that will be taken to address any issues that are identified as a root cause. This portion of the RCA delineates the items that are being addressed, the strategies that will be implemented, and the measures that will be used to determine the effectiveness of the plan.

QUALITY IMPROVEMENT ACTIVITY

SERIOUS INCIDENT ROOT CAUSE ANALYSIS WORKSHEET

Date and Time of Serious Incident: _____

| | | | | | | | | | | | | | | | | | |
|---------------------------------|---|------------------------|-----------------------------|---------------------------------|-------------------------|--------------------------|---|------------------------|--------------------|--------------|-----------------------------|--------------|--|-----------------------|--------------------------------|---------------------------------|--|
| (1) Summary of incident: | (List type of serious incident and explain what happened. Include who was involved, services impacted, including any outside parties or witnesses, details of the incident, and the outcome/injury) | | | | | | | | | | | | | | | | |
| (2) Participants: | (List all the participants by position and title {no names} involved in the root cause analysis and action plan. Note the Lead of the RCA and the facilitator.) | | | | | | | | | | | | | | | | |
| (3) Systems and Processes: | <p>(Note systems and processes that were analyzed to determine proximate causes)</p> <p style="text-align: center;">List of possible systems and processes for review:</p> <table border="0"> <tr> <td>___ Assessment Process</td><td>___ Risk Assessment Process</td></tr> <tr> <td>___ Physical Assessment Process</td><td>___ Reception protocols</td></tr> <tr> <td>___ Medication Protocols</td><td>___ Control of medications, storage, access</td></tr> <tr> <td>___ Staffing resources</td><td>___ Staff training</td></tr> <tr> <td>___ Security</td><td>___ Policies and Procedures</td></tr> <tr> <td>___ Facility</td><td>___ Communications with client or family</td></tr> <tr> <td>___ Care Coordination</td><td>___ Communications among staff</td></tr> <tr> <td>___ Availability of information</td><td></td></tr> </table> <p>Other: _____</p> | ___ Assessment Process | ___ Risk Assessment Process | ___ Physical Assessment Process | ___ Reception protocols | ___ Medication Protocols | ___ Control of medications, storage, access | ___ Staffing resources | ___ Staff training | ___ Security | ___ Policies and Procedures | ___ Facility | ___ Communications with client or family | ___ Care Coordination | ___ Communications among staff | ___ Availability of information | |
| ___ Assessment Process | ___ Risk Assessment Process | | | | | | | | | | | | | | | | |
| ___ Physical Assessment Process | ___ Reception protocols | | | | | | | | | | | | | | | | |
| ___ Medication Protocols | ___ Control of medications, storage, access | | | | | | | | | | | | | | | | |
| ___ Staffing resources | ___ Staff training | | | | | | | | | | | | | | | | |
| ___ Security | ___ Policies and Procedures | | | | | | | | | | | | | | | | |
| ___ Facility | ___ Communications with client or family | | | | | | | | | | | | | | | | |
| ___ Care Coordination | ___ Communications among staff | | | | | | | | | | | | | | | | |
| ___ Availability of information | | | | | | | | | | | | | | | | | |

QUALITY IMPROVEMENT ACTIVITY

| (3) Note each Process to be considered for review and definition | (4) What are the steps in the process as designed? (A flow diagram is recommended) | (5) Findings | (6) Root Cause? | | (7) Take Action? |
|--|--|--------------|-----------------|----|------------------|
| | | | Yes | No | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

QUALITY IMPROVEMENT ACTIVITY

| (8) Action Plan | | |
|--------------------------|-------------------------------|-------------------------------|
| (a) List of Action Items | (b) Risk reduction strategies | (c) Measures of Effectiveness |
| Action item 1: | | |
| Action Item 2: | | |
| Action item 3: | | |
| Action item 4: | | |
| Etc...as needed | | |

QUALITY IMPROVEMENT ACTIVITY

SERIOUS INCIDENT ROOT CAUSE ANALYSIS WORKSHEET

Date and Time of Serious Incident: ___Aug 1, 2010_____

| | | | | | | | | | | | | | | | | | |
|--|---|---|---|--|---|--|--|--|--|-----------------------------------|--|-----------------------------------|---|--|---|--|--|
| <p>(1) Summary of incident:</p> | <p>(List type of serious incident and explain what happened. Include who was involved, services impacted, including any outside parties or witnesses, details of the incident, and the outcome/injury)</p> <p>Client, A.N.O.N, committed suicide Friday night at approximately 9:30 PM. Last appointment at clinic Wednesday for meds support, but client missed appointment. Client came in on Friday to see therapist but Receptionist, told client that therapist was on vacation and tried to set up an appointment the following week. No outside parties or witnesses. Client stepped in front of train. Paramedics were called to the scene</p> | | | | | | | | | | | | | | | | |
| <p>(2) Participants:</p> | <p>(List all the participants by position and title {no names} involved in the root cause analysis and action plan)</p> <table border="0"> <tr> <td>Program Manager</td> <td>Supervisor of Clerical Staff</td> </tr> <tr> <td>Lead Therapist</td> <td>Therapist</td> </tr> <tr> <td>Director of Clinical Operations</td> <td>Doctor</td> </tr> <tr> <td>Receptionist</td> <td></td> </tr> </table> | Program Manager | Supervisor of Clerical Staff | Lead Therapist | Therapist | Director of Clinical Operations | Doctor | Receptionist | | | | | | | | | |
| Program Manager | Supervisor of Clerical Staff | | | | | | | | | | | | | | | | |
| Lead Therapist | Therapist | | | | | | | | | | | | | | | | |
| Director of Clinical Operations | Doctor | | | | | | | | | | | | | | | | |
| Receptionist | | | | | | | | | | | | | | | | | |
| <p>(3) Systems and Processes:</p> | <p>(Note systems and processes that were analyzed to determine proximate causes)</p> <p>List of systems and processes:</p> <table border="0"> <tr> <td><input type="checkbox"/> Assessment Process</td> <td><input checked="" type="checkbox"/> Risk Assessment Process</td> </tr> <tr> <td><input type="checkbox"/> Physical Assessment Process</td> <td><input checked="" type="checkbox"/> Reception protocols</td> </tr> <tr> <td><input checked="" type="checkbox"/> Medication Protocols</td> <td><input type="checkbox"/> Control of medications, storage, access</td> </tr> <tr> <td><input checked="" type="checkbox"/> Staffing resources</td> <td><input checked="" type="checkbox"/> Staff training</td> </tr> <tr> <td><input type="checkbox"/> Security</td> <td><input type="checkbox"/> Policies and Procedures</td> </tr> <tr> <td><input type="checkbox"/> Facility</td> <td><input type="checkbox"/> Communications with client or family</td> </tr> <tr> <td><input type="checkbox"/> Care Coordination</td> <td><input type="checkbox"/> Communications among staff</td> </tr> <tr> <td><input type="checkbox"/> Availability of information</td> <td></td> </tr> </table> <p>Other: _____</p> | <input type="checkbox"/> Assessment Process | <input checked="" type="checkbox"/> Risk Assessment Process | <input type="checkbox"/> Physical Assessment Process | <input checked="" type="checkbox"/> Reception protocols | <input checked="" type="checkbox"/> Medication Protocols | <input type="checkbox"/> Control of medications, storage, access | <input checked="" type="checkbox"/> Staffing resources | <input checked="" type="checkbox"/> Staff training | <input type="checkbox"/> Security | <input type="checkbox"/> Policies and Procedures | <input type="checkbox"/> Facility | <input type="checkbox"/> Communications with client or family | <input type="checkbox"/> Care Coordination | <input type="checkbox"/> Communications among staff | <input type="checkbox"/> Availability of information | |
| <input type="checkbox"/> Assessment Process | <input checked="" type="checkbox"/> Risk Assessment Process | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Physical Assessment Process | <input checked="" type="checkbox"/> Reception protocols | | | | | | | | | | | | | | | | |
| <input checked="" type="checkbox"/> Medication Protocols | <input type="checkbox"/> Control of medications, storage, access | | | | | | | | | | | | | | | | |
| <input checked="" type="checkbox"/> Staffing resources | <input checked="" type="checkbox"/> Staff training | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Security | <input type="checkbox"/> Policies and Procedures | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Facility | <input type="checkbox"/> Communications with client or family | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Care Coordination | <input type="checkbox"/> Communications among staff | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Availability of information | | | | | | | | | | | | | | | | | |

QUALITY IMPROVEMENT ACTIVITY

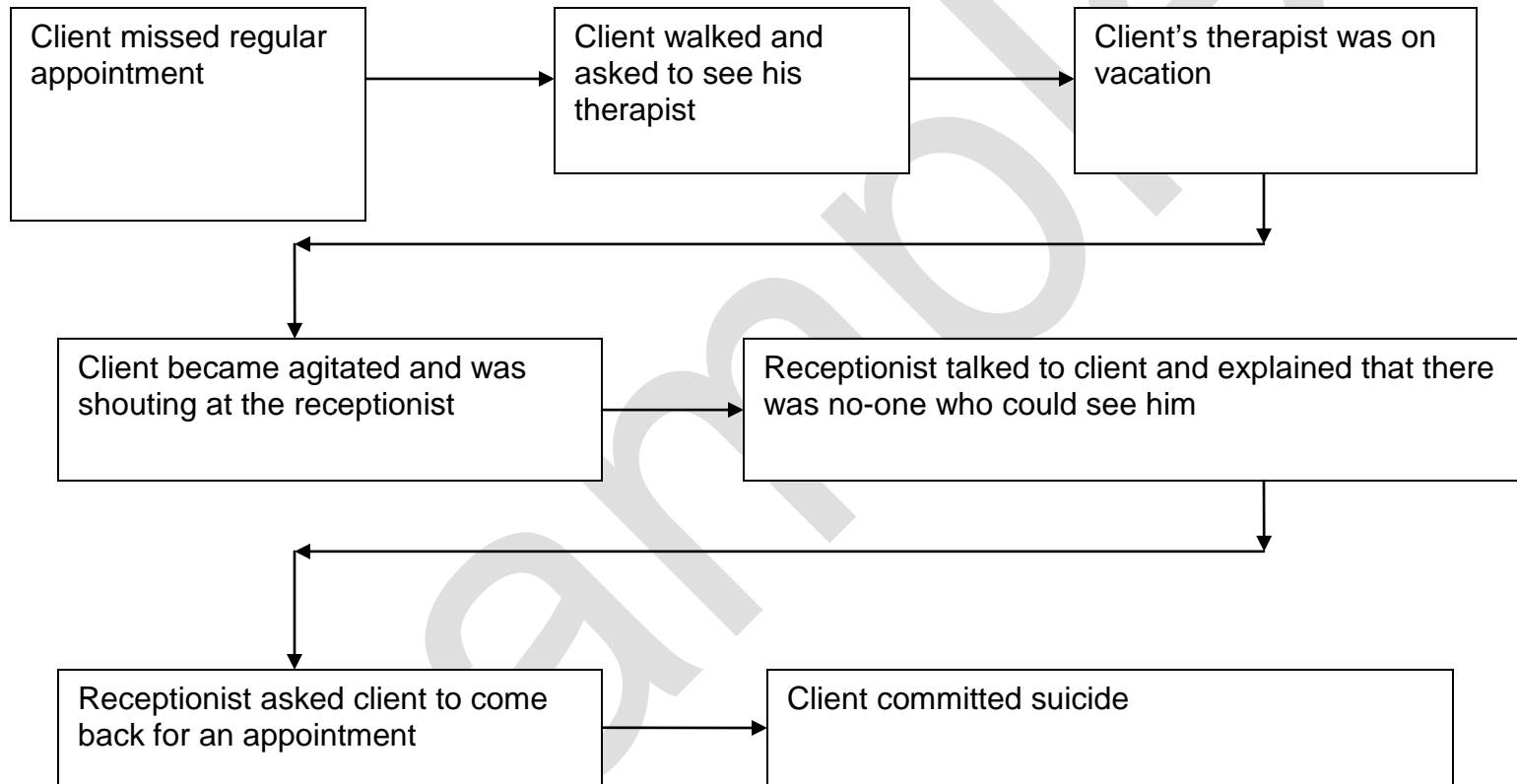
| (3) Note each Process to be considered for review and definition | (4) What are the steps in the process as designed? (A workflow diagram is recommended) | (5) Findings | (6) Root Cause? | | (7) Take Action? |
|--|---|--|-----------------|----|--|
| | | | Yes | No | |
| Medication Protocols- Missed Appointment | When a client misses a meds appointment, nurse is to review client record for potential problems with meds | Record was reviewed and protocol for following missed appointment was followed | | x | |
| Reception Protocols- Agitated client | When a client, whose therapist or MD is on vacation or sick, walks in to ask for an urgent appointment reception should contact another therapist to talk with client | Policy is not standardized and there is no current process to have an assigned triage staff on duty. | x | | Develop action plan to ensure new policy is drafted and triage process established |
| Staffing Resources- Therapist on vacation | When a therapist is on vacation a back up system is implemented for all high risk clients | Back up system was implemented, but back up therapist was out sick when client came in. | x | | Improve communications (see below) |
| Risk Assessment Process- High Risk Client | High risk clients are identified and all program staff are aware of potential problems. (see sample workflow) | Process was not followed due to MIS being down. | x | | Develop action plan to brainstorm solutions |
| Staff Training- receptionist | Receptionists shall receive training on how to work with consumers who may be agitated when they come in | Receptionist was not trained as regular trainer is out on maternity leave. | x | | Develop action plan to ensure training |

QUALITY IMPROVEMENT ACTIVITY

| (8) Action Plan | | |
|--|---|--|
| (a) List of Action Items | (b) Risk reduction strategies | (c) Measures of Effectiveness |
| Action item 1: Develop action plan to ensure new policy is drafted | Draft new policy about coverage to sick days and vacation days. Train all staff | Track number of clients seen by back up when regular therapist/MD is on vacation or sick. Ask clients how satisfied they were with that services |
| Action Item 2: Establish triage process | Develop new process for “daily triage duty” assignments | Number of contacts made by staff on daily triage duty Ask consumers if the triage process helped Note # of further incidents after daily triage duty process developed |
| Action item 3: Develop action plan to brainstorm solutions for communicating about high risk clients that addresses possible MIS outages | Plan a workgroup to meet and brainstorm solutions. Post new processes or protocols for all staff | Number of incidents that occur for clients designated as high risk clients |
| Action item 4: Develop action plan to ensure training for receptionists on handling difficult situations | Train more staff to be able to provide the training for receptionists Establish a policy that all receptionists must be trained before their first day | Number of difficult situations at the reception area Outcome of difficult situations |

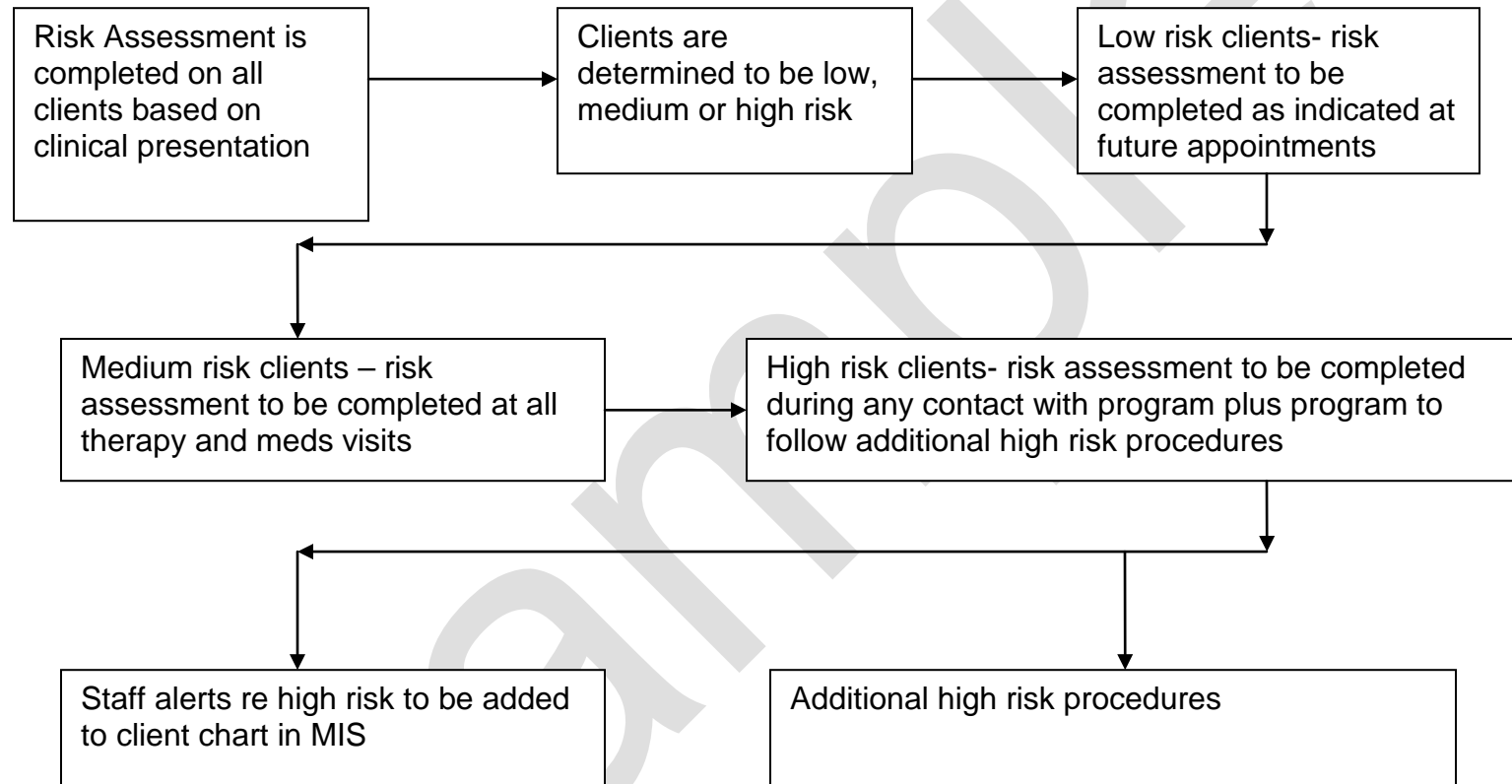
QUALITY IMPROVEMENT ACTIVITY

Workflow for Serious Incident



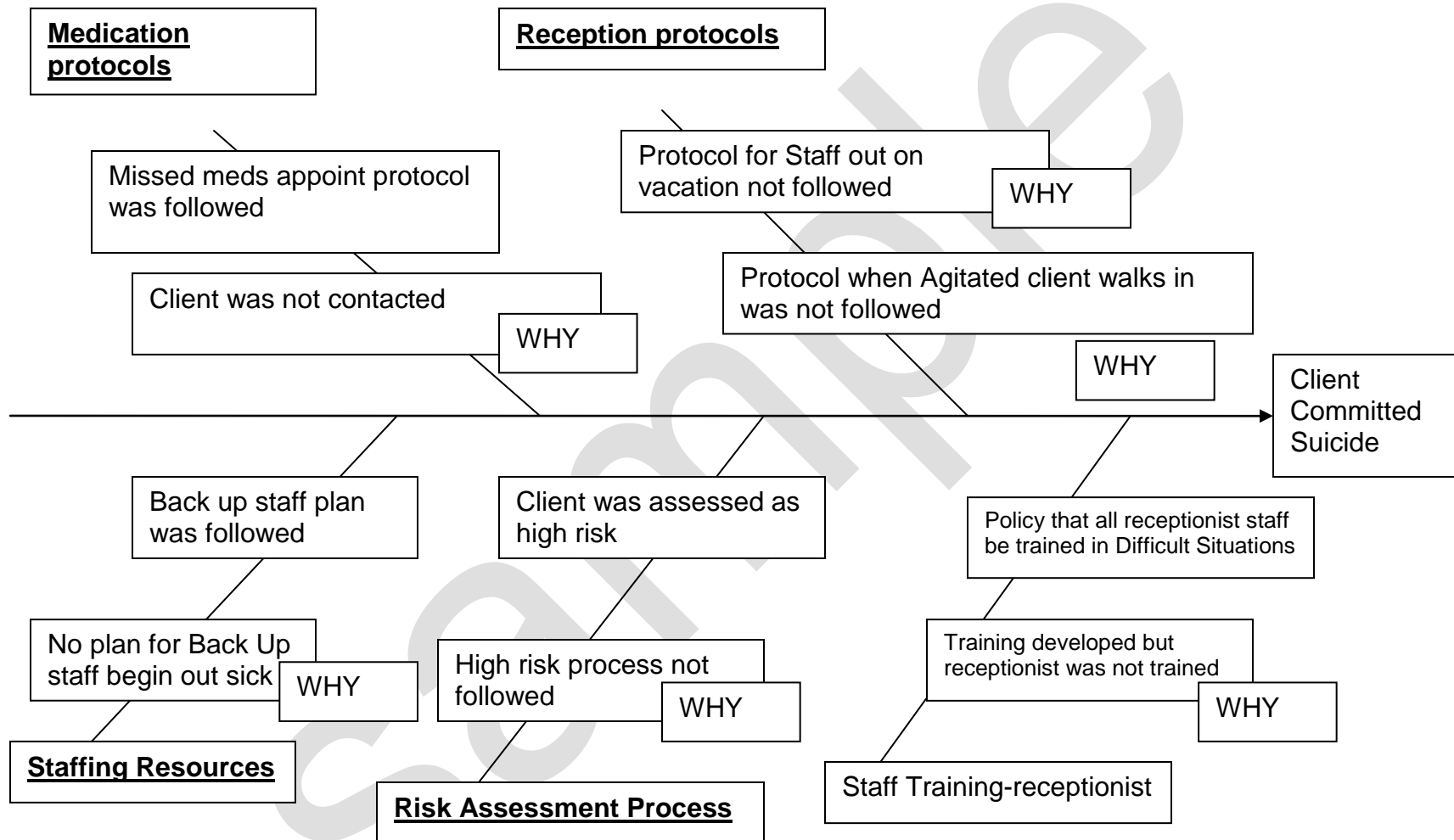
QUALITY IMPROVEMENT ACTIVITY

Workflow for Risk Assessment Process- High Risk Client



QUALITY IMPROVEMENT ACTIVITY

Fishbone Analysis



QI Medication Monitoring Report

Adult Mental Health System of Care

| | | | |
|---|--|--|--|
| PROGRAM NAME: | | | |
| | | | |
| DATE: | | UNIT: | SUBUNIT(S): |
| | | | |
| REPORT SUBMITTED BY: | | | PHONE: |
| | | | |
| <input checked="" type="radio"/> QUARTER 1 Jul 1 – Sep 30 <i>Due Oct 15</i> | <input type="radio"/> QUARTER 2 Oct 1 – Dec 31 <i>Due Jan 15</i> | <input type="radio"/> QUARTER 3 Jan 1 – Mar 31 <i>Due Apr 15</i> | <input type="radio"/> QUARTER 4 Apr 1 – Jun 30 <i>Due Jul 15</i> |

Committee Member

Discipline

Committee Member

Discipline

Description of Activities:

| | | | |
|--|--|--|-------------------------------|
| | Total number of records screened this quarter | | # McFloops Approved/Completed |
| | Total number of variances identified | | # McFloops Outstanding |
| | Total number of McFloops required | | |
| | # McFloops Disapproved <i>Disapproved McFloop forms must be faxed in</i> | | |

Total number of variances for all records screened this quarter, listed by item:

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8a | 8b | 8c | 8d |
|---|---|---|---|---|---|---|----|----|----|----|
| | | | | | | | | | | |

Email this form to: QIMatters.hhhsa@sdcounty.ca.gov

Do not email Med Monitoring Tools

Do not email McFloop Forms

This form may also be faxed to the QI Unit at 619-236-1953

QI Medication Monitoring Report

Children's Mental Health System of Care

| | | | |
|---|--|--|--|
| PROGRAM NAME: | | | |
| | | | |
| DATE: | | UNIT: | SUBUNIT(S): |
| | | | |
| REPORT SUBMITTED BY: | | | PHONE: |
| | | | |
| <input checked="" type="radio"/> QUARTER 1 Jul 1 – Sep 30 <i>Due Oct 15</i> | <input type="radio"/> QUARTER 2 Oct 1 – Dec 31 <i>Due Jan 15</i> | <input type="radio"/> QUARTER 3 Jan 1 – Mar 31 <i>Due Apr 15</i> | <input type="radio"/> QUARTER 4 Apr 1 – Jun 30 <i>Due Jul 15</i> |

Committee Member

Discipline

Committee Member

Discipline

☐ **No medication distribution during this quarter**

Description of Activities:

| | | | |
|--|---|---|-------------------------------|
| | Total number of records screened this quarter | | # McFloops Approved/Completed |
| | Total number of variances identified | | # McFloops Outstanding |
| | Total number of McFloops required | | |
| | # McFloops Disapproved | <i>Disapproved McFloop forms must be faxed in</i> | |

Total number of variances for all records screened this quarter, listed by item:

| 1 | 2 | 3 | 4 | 4a | 4b | 4c | 4d | 4e |
|---|---|---|---|----|----|----|----|----|
| | | | | | | | | |

| 5 | 6 | 7 | 8a | 8b | 8c | 8d |
|---|---|---|----|----|----|----|
| | | | | | | |

Email this form to: QIMatters.hhsa@sdcounty.ca.gov

Do not email Med Monitoring Tools

Do not email McFloop Forms

This form may also be faxed to the QI Unit at 619-236-1953

[illegible]

[illegible]

Appendix H Cultural Competence

Culturally Competent Program Annual Self-Evaluation

CC-PAS

Culturally Competent Program Annual Self-Evaluation

The Culturally Competent Program Annual Self-Evaluation (CC-PAS) tool has been developed by San Diego County Mental Health to be used by programs to rate themselves as to their current capability for providing culturally competent services. The CC-PAS Protocol is based on expectations and standards recommended by the Cultural Competence Resource Team (CCRT) and endorsed by the Quality Review Council (QRC). Once the CC-PAS has been completed programs should use the space at the end of the CC-PAS to develop new or revised objectives the program's Cultural Competence Plan that will support ratings with improved scores during the next rating period.

Directions for scoring for CC-PAS Protocol:

- Review each item and fill out the description as to the status for your program. Add attachments as possible to support your position.
- Determine if your program has Met, Partially Met or Not Met the stated standard using the description of the standard noted for each category.
- Tally the score in each category using the following scale:
 - 5 points for Met Standard
 - 3 points for Partially Met Standard
 - 1 point for Standard Not Met
- Determine the total score.
- If there are certain topics that your program would benefit from having technical assistance you can note that by checking:
 - ____ Technical Assistance needed.
- Keep a record of the results of the CC-PAS to use to evaluate your progress over time.
- Repeat the CC-PAS annually
- Some items may not be applicable if program is not a direct service provider.

CC-PAS Protocol:

- 1) The program/facility has developed a Cultural Competence Plan.
Attach a copy of the Cultural Competence Plan or describe the plan.
-

☐ Met: Program has a written Cultural Competence Plan that addresses the specific needs of that program.

☐ Partially Met: Legal Entity has a written Cultural Competence Plan but the specific needs of that program are not identified or there is no written Cultural Competence Plan but there is some other evidence of a plan.

☐ Not met: There is no plan to achieve Cultural Competence for the program.

Note: QI Unit will supply a format that may be used for developing a Cultural Competence Plan if one is needed

____ Technical Assistance needed

Score = ____

- 2) The program/facility has assessed *the strengths* and needs for services in their community.
Describe the strengths and need for services: _____

☐ Met : The strengths and needs of the community are clearly identified in the Cultural Competence Plan. Community members, Program Advisory Groups, and other stakeholders have participated in the identification of the strengths and needs of the community.

☐ Partially Met: The strengths and needs of the community are not clearly identified in the Cultural Competence Plan but there is evidence that the program is aware of the strengths and needs of the community

☐ Not met: The program is not aware of the strengths and needs of the community

____ Technical Assistance needed

Score = ____

- 3) The staff in the program/facility reflects the diversity within the community.
Attach a report that demonstrates the staff and compares the composition of the staff to the community or describe: _____

☐ Met: The diversity of staff in the program closely matches the demographics in the community, and there is evidence that this is a goal the program is working to achieve.

☐ Partially Met: The diversity of staff in the program somewhat matches the demographics in the community, and there is evidence that this is a goal the program is working to achieve.

☐ Not met: The staff in the program does not closely match the demographics in the community, and there is no evidence that this is a goal the program is working to achieve.

____ Technical Assistance needed

Score = ____

- 4) The program/facility has a process in place for ensuring language competence of direct services staff who identify themselves as bi-or multi –lingual.
Attach or Describe the process: _____

Culturally Competent Program Annual Self-Evaluation 9/2009

- ☐ Met: The program has a policy or written process for testing the language competence of direct services staff who identify themselves as bi- or multi –lingual. There is training available for any staff who are bi-lingual or who provide interpreter services to ensure that language needs are being met. The program also surveys clients and family members to assure language competence.
- ☐ Partially Met: The program has an informal process for testing the language competence of direct services staff who identify themselves as bi or multi –lingual.
- ☐ Not met: The program does not have process for testing the language competence of direct services staff who identify themselves as bi or multi –lingual.
- ☐ Not applicable if program is not a direct service provider.

____ Technical Assistance needed

Score = ____

5) The program/facility has a process in place for ensuring language competence of support services staff who identify themselves as bi or multi –lingual.

Describe the process: _____

- ☐ Met: The program has a policy or written process for testing the language competence of support services staff who identify themselves as bi or multi –lingual. There is training available for any staff who are bi-lingual or who provide interpreter services to ensure that language needs are being met.
- ☐ Partially Met: The program has an informal process for testing the language competence of support services staff who identify themselves as bi or multi –lingual.
- ☐ Not met: The program has no process for testing the language competence of support services staff who identify themselves as bi or multi –lingual.

____ Technical Assistance needed

Score = ____

6) The program/facility supports/provides interpreter training of direct and indirect services staff.

Describe the process: _____

- ☐ Met: The program has evidence that demonstrates interpreter training of direct and indirect services staff
- ☐ Partially Met: There is informal interpreter services training of direct services staff
- ☐ Not met: There has been no interpreter services training of direct services staff

____ Technical Assistance needed

Score = ____

7) The program/facility uses language interpreters as needed.

Describe the use of language interpreters and languages used? _____

- ☐ Met: The program frequently uses language interpreters, and can consistently demonstrate the offer of interpreters in progress notes.
- ☐ Partially Met : The program occasionally uses language interpreters.
- ☐ Not met: The program does not use language interpreters and can not demonstrate the offer of interpreters

____ Technical Assistance needed

Score = ____

Culturally Competent Program Annual Self-Evaluation 9/2009

8) The program/facility has a process in place for assessing cultural competence of direct services/ support services staff.

Describe the process: _____

- ☐ Met: The program/facility has a written/formal process in place for assessing cultural competence of direct services/ support services staff and can demonstrate the results of those assessments. Additionally, the process includes input from clients and family members
- ☐ Partially Met: The program/facility has a process in place for assessing cultural competence of direct services/ support services staff
- ☐ Not met: The program/facility has no process in place for assessing cultural competence of direct services/ support services staff

_____ Technical Assistance needed

Score = _____

9) The program/facility has a process in place for direct services/ support services staff to self assess cultural competence (e.g. California Brief Multi Competence Scale- CBMCS)

Describe the process: _____

- ☐ Met: The program has a requirement at the time staff are hired, and then periodically after hire, for all staff to complete the CMCBS or a similar tool and has evidence of the results of those evaluations. The program uses the evaluation to identify training needs.
- ☐ Partially Met: The program encourages staff to complete the CMCBS or a similar tool.
- ☐ Not met: The program does not support opportunities for staff to complete the CMCBS or a similar tool and has evidence of the results of the those evaluations,

_____ Technical Assistance needed

Score = _____

10) The program/facility has conducted a survey amongst their clients to determine if the program is perceived as being culturally competent.

Describe the results of the survey: _____

- ☐ Met: The program/facility has conducted a survey amongst their clients and their family members to determine if the program is perceived as being culturally competent.
- ☐ Partially Met: The program/facility is using the annual State survey to determine if the program is perceived as being culturally competent
- ☐ Not met: The program/facility is not using any type of survey to determine if the program is perceived as being culturally competent.

_____ Technical Assistance needed

Score = _____

11) The program/facility conducted a survey amongst their clients to determine if the program's clinical services are perceived as being culturally competent.

Describe the results of the survey: _____

- ☐ Met: The program/facility has conducted a survey amongst their clients to determine if the program's clinical services are perceived as being culturally competent
- ☐ Partially Met: The program/facility uses the annual State survey to determine if the program's clinical services are perceived as being culturally competent

Culturally Competent Program Annual Self-Evaluation 9/2009

☐ Not met: The program/facility does not use a survey amongst their clients to determine if the program's clinical services are perceived as being culturally competent

____ Technical Assistance needed

Score = ____

12) The program utilizes the Culturally Competent Clinical Practice Standards.

Describe how the standards are utilized: _____

☐ Met: The program utilizes the Culturally Competent Clinical Practice Standards and trains all staff and managers at least annually.

☐ Partially Met: The program utilizes the Culturally Competent Clinical Practice Standards but has little or no training.

☐ Not met: The program does not utilize the Culturally Competent Clinical Practice Standards

☐ Not applicable if program is not a direct service provider.

____ Technical Assistance needed

Score = ____

13) The program/facility supports cultural competence training of direct services staff.

Describe the process: _____

☐ Met: The program/facility supports cultural competence training of direct services staff and 80 to 100% of staff have attended at least 4 hours of training.

☐ Partially Met : The program/facility supports cultural competence training of direct services staff and 50-79% of staff have attended at least 4 hours of training

☐ Not met: The program/facility does not support cultural competence training of direct services staff

____ Technical Assistance needed

Score = ____

14) The program/facility supports cultural competence training of support services staff.

Describe the process: _____

☐ Met: The program/facility supports cultural competence training of support services staff and 80 to 100% of staff have attended at least 4 hours of training.

☐ Partially Met: The program/facility supports cultural competence training of support services staff and 50-79% of staff have attended at least 4 hours of training

☐ Not met: The program/facility does not support cultural competence training of support services staff

____ Technical Assistance needed

Score = ____

15) Services provided are designed to meet the needs of the community.

Describe how the services meet the needs of the community:

☐ Met: Services provided include additional hours, child care, transportation or other options that are targeted to meet the specific community needs.

☐ Partially Met: Services provided include groups that are targeted to meet the specific community needs.

Culturally Competent Program Annual Self-Evaluation 9/2009

☐ Not met: Services provided include do not include options that are targeted to meet the specific community needs.

____ Technical Assistance needed

Score = ____

16) The program has implemented the use of any Evidence Based Practices, or best practice guidelines *appropriate for the populations served*.

Describe the practices: _____

☐ Met: The program has implemented the use of Evidence Based Practices, or best practice guidelines *appropriate for the populations served*

☐ Partially Met: The program has implemented the use of any Evidence Based Practices, or best practice guidelines

☐ Not met: The program has not implemented the use of any Evidence Based Practices, or best practice guidelines

☐ Not applicable if program is not a direct service provider.

____ Technical Assistance needed

Score = ____

17) The program collects client outcomes *appropriate for the populations served*.

Describe the client outcomes that are collected and how the information is used:

☐ Met: The program collects client outcomes *appropriate for the populations served*

☐ Partially Met: The program collects client outcomes

☐ Not met: The program does not collect client outcomes.

☐ Not applicable if program is not a direct service provider.

____ Technical Assistance needed

Score = ____

18) The program conducts outreach efforts *appropriate for the populations in the community*

Describe the outreach efforts: _____

☐ Met : The program conducts effective and on-going outreach efforts *appropriate for the populations in the community*

☐ Partially Met: The program conducts occasional outreach efforts *appropriate for the populations in the community*

☐ Not met: The program does not conducts outreach efforts.

____ Technical Assistance needed

Score = ____

19) The program is responsive to the variety of stressors that may impact the communities served.

Examples of responsiveness: _____

☐ Met: The program is responsive to the variety of stressors that may impact the communities served and can demonstrate responsiveness.

☐ Partially Met : The program is aware of the variety of stressors that may impact the communities served

Culturally Competent Program Annual Self-Evaluation 9/2009

☐ Not met: The program not aware of stressors that may have an impact on the communities served

____ Technical Assistance needed

Score = ____

20) The program reflects its commitment to cultural and linguistic competence in all policy and practice documents including it's mission statement, strategic plan, and budgeting practices.

Examples of commitment: _____

☐ Met: The program reflects its commitment to cultural and linguistic competence in all policy and practice documents including it's mission statement, strategic plan, and budgeting practices.

☐ Partially Met: The program reflects its commitment to cultural and linguistic competence in some policy and practice documents including it's mission statement, strategic plan, and budgeting practices.

☐ Not met: The program does not reflects its commitment to cultural and linguistic competence in all policy and practice documents including it's mission statement, strategic plan, and budgeting practices.

____ Technical Assistance needed

Score = ____

After completing all of the items, #'s 1- 20 above, add all the individual scores together to come up with a CC-PAS rating for the program

Total score = _____

New or revised objectives for the programs Cultural Competence Plan:

**California Brief Multicultural Competence Scale
(CBMCS)**

Below is a list of statements dealing with multicultural issues within a mental health context. Please indicate the degree to which you agree with each statement by circling the appropriate number.

| | Strongly Disagree | Disagree | Agree |
|---|----------------------|----------|-------|
| Strongly Agree | Disagree | | |
| 1. I am aware that being born a minority in this society brings with it certain 4 challenges that White people do not have to face. | 1 | 2 | 3 |
| 2. I am aware of how my own values might affect my client. 4 | 1 | 2 | 3 |
| 3. I have an excellent ability to assess, accurately, the mental health needs of 4 persons with disabilities. | 1 | 2 | 3 |
| 4. I am aware of institutional barriers that affect the client. 4 | 1 | 2 | 3 |
| 5. I have an excellent ability to assess, accurately, the mental health needs of 4 lesbians. | 1 | 2 | 3 |
| 6. I have an excellent ability to assess, accurately, the mental health needs of 4 older adults. | 1 | 2 | 3 |
| 7. I have an excellent ability to identify the strengths and weaknesses of 4 psychological tests in terms of their use with persons from different cultural, racial and/or ethnic backgrounds. | 1 | 2 | 3 |
| 8. I am aware that counselors frequently impose their own cultural values upon 4 minority clients. | 1 | 2 | 3 |
| 9. My communication skills are appropriate for my clients. 4 | 1 | 2 | 3 |
| 10. I am aware that being born a White person in this society carries with it certain 4 Advantages. | 1 | 2 | 3 |
| 11. I am aware of how my cultural background and experiences have influenced my 4 attitudes about psychological processes. | 1 | 2 | 3 |
| 12. I have an excellent ability to critique multicultural research. 4 | 1 | 2 | 3 |
| 13. I have an excellent ability to assess, accurately, the mental health needs of men. 4 | 1 | 2 | 3 |
| 14. I am aware of institutional barriers that may inhibit minorities from using mental 4 health services. | 1 | 2 | 3 |

| | | | |
|---|---|---|---|
| 15. I can discuss, within a group, the differences among ethnic groups (e.g. low 4 socioeconomic status (SES), Puerto Rican client vs. high SES Puerto Rican client). | 1 | 2 | 3 |
| 16. I can identify my reactions that are based on stereotypical beliefs about different 4 ethnic groups. | 1 | 2 | 3 |
| 17. I can discuss research regarding mental health issues and culturally different 4 populations. | 1 | 2 | 3 |
| 18. I have an excellent ability to assess, accurately, the mental health needs of 4 gay men. | 1 | 2 | 3 |
| 19. I am knowledgeable of acculturation models for various ethnic minority groups. 4 | 1 | 2 | 3 |
| 20. I have an excellent ability to assess, accurately, the mental health needs of women. 4. | 1 | 2 | 3 |
| 21. I have an excellent ability to assess, accurately, the mental health needs of 4 persons who come from very poor socioeconomic backgrounds. | 1 | 2 | 3 |

Gamst, G., Dana, R. H., Der-Karabetian, A., Aragon, M., Arellano, L., Morrow, G., & Martenson, L. (2004). Cultural competency Revised: The California Brief Multicultural Competency Scale. *Measurement and Evaluation in Counseling and Development*, 37, 3,163-187.

Organizational Provider Operations Handbook

Appendix I Management Information System

ANASAZI REQUEST FORM (ARF) – MENTAL HEALTH PROGRAMS

MENTAL HEALTH MANAGEMENT INFORMATION SYSTEM (MHMIS)

FAX FORM TO MHMIS UNIT: 858-467-0411

ALL FORMS MUST BE COMPLETE AND TYPED OR THEY WILL BE RETURNED.

[1] USER TYPE REQUEST

- ☐ New User ☐ Modify Current User
 Anasazi Staff ID#
 Citrix Staff ID
- ☐ Terminate User; Termination Date:
 Anasazi Staff ID#
 Citrix Staff ID

[2] PROGRAM INFORMATION

- ☐ County Staff ☐ Non-County Staff
- Program Name:
 LE/Parent Org:
 User Job Title:
 Employment Start Date:

[3] USER INFORMATION

* If Name Change, please use new name below and enter previous name here:

First Name: MI: Last Name: Work Phone: Ext:

Primary Work Street Address: Last 5 of SSN:

City: State: Zip: User Work Email:

[4] MENU GROUP None

If Clinical Menu is selected, enter Assessments Training date
 If Data Entry Menu is selected, enter New Hire/Service Entry Training date
 If Scheduler Menu is selected, enter Scheduler training date
 If Program Manager or 24 Hour Menu is selected, enter Assessments and New Hire/Service Entry dates above.

[5] UNIT/SUBUNIT ACCESS (LIST ALL UNITS AND SUBUNITS TO WHICH USER REQUIRES ACCESS)

| | | | |
|-------|-------------|-------|-------------|
| Unit: | Subunit(s): | Unit: | Subunit(s): |
| Unit: | Subunit(s): | Unit: | Subunit(s): |
| Unit: | Subunit(s): | Unit: | Subunit(s): |

[6] CREDENTIAL & CERTIFICATION INFORMATION☐ No Credential – Administrative StaffOR Select Credential: Unlicensed **Blank** OR Select Credential: Licensed **Blank**

License or Registration # state of issuance NPI # TAXONOMY #

If User is a Medicare certified provider, provide PTAN and effective date:

[7] LANGUAGES SPOKEN

Language #1: Language #2: Language #3: Language #4 :

[8] COMMENTS:**[9] PROGRAM CONTACT INFORMATION** (FOR MHMIS QUESTIONS)

First Name: Last Name: Work Email: Phone:

[10] USER ACCESS AUTHORIZATION

User Signature: _____

First Name: Last Name: Date:

Pursuant to the contractual agreement on file with the County of San Diego and as designated by my corporate office, I am authorizing access as noted above and affirm that I have personally reviewed the County's Summary of Policies with the above user.

Authorizing Program Manager Signature: _____

First Name: Last Name: Date:

MHMIS Unit Only: ☐ Anasazi ☐ CSRF ☐ NPI ☐ SESA **EFFECTIVE DATE:** **Staff ID:**



COUNTY OF SAN DIEGO

Summary of Policies Regarding County Data/Information and Information Systems

To aid in the performance of their regular job assignments and duties, County employees, volunteers, agents and contractors are provided access to many County tools and resources. In the electronic age, these tools and resources include County "data/information" in various formats (e.g. on electronic media, paper, microfiche) and County "information systems" (e.g. computers, servers, networks, Internet access, fax, telephones and voice mail), whether owned, provided or maintained by or on behalf of the County.

The County has established policies and procedures based on best business practices to support the performance of the County's business and to protect the integrity, security and confidentiality of the County's data/information and information systems. Users¹ of these resources play a critical role. By carrying out their regular assignments and duties in compliance with all applicable County's policies and procedures, best practices are maintained.

This summary helps users know their responsibilities by highlighting important aspects of policies that govern access to and use of County data/information and information systems. The policies themselves provide further detailed information governing the use of County data/information and information systems and should be reviewed. Most notably, the County Chief Administrative Officer (CAO) Policy *Acceptable Use of County Data/Information* provides additional guidance on protecting County data/information; the CAO Policy *County Information Systems – Management and Use* provides guidance in controlling and using County information systems; and the CAO Policy *Telecommunications – Management and Use* provides guidance in using desktop and cellular telephones.

Access to County data/information or information systems is necessary to the performance of regular assignments and duties. Failure to comply with these policies and procedures may constitute a failure in the performance of regular assignments/duties. Such failure can result in the temporary or permanent denial of access privileges and/or in discipline, up to and including termination, in accordance with Civil Service Rules.

1. County data/information in all formats and information systems are for authorized County use only. Personal use of County information systems is prohibited unless specifically authorized by the Appointing Authority.
2. As part of their regular assignments and duties, users are responsible for protecting any data / information and information systems provided or accessible to them in connection with County business or programs.
3. Users cannot share data/information with others outside of their regular duties and responsibilities unless specifically authorized to do so.
4. Users have no expectation of privacy regarding any data/information created, stored, received, viewed, accessed, deleted or input via County information systems. The County retains the right to monitor, access, retrieve, restore, delete or disclose such data/information.

¹ For purposes of this summary, the term "user" shall refer to any person authorized to use County data/information and information systems to perform work in support of the business, programs or projects in which the County is engaged. It also applies to users accessing other networks, including the Internet, through County information systems.

5. Attempts by users to access any data or programs contained on County information systems for which they do not have authorization will be considered a misuse.
6. Users shall not share their County account(s) or account password(s) with anyone, use another's account to masquerade as that person, or falsely identify themselves during the use of County information systems.
7. The integrity and security of County data/information depends on the observation of proper business practices by all authorized users. Users are requested to report any weaknesses in County information system security and any incidents of possible misuse or violation of County IT policies to the appropriate County representative.
8. Users shall not divulge Dial-up or Dial-back modem phone numbers to anyone.
9. Users shall not make copies of system configuration files (e.g. password files) for their own unauthorized use or to provide to other people/users for unauthorized uses.
10. Users shall not make copies of copyrighted software or information, except as permitted by law or by the owner of the copyright.
11. Users shall not engage in any activity that harasses, defames or threatens others, degrades the performance of information systems, deprives an authorized County user access to a County resource, or circumvents County security measures.
12. Users shall not download, install or run security programs or utilities that reveal or exploit weaknesses in the security of a County information system. For example, County users shall not run password cracking or network scanning programs on County information systems.

Misuse of workplace tools and resources, including County data/information and/or County information systems, will be reported to a user's management. Misuse may constitute a failure to perform regular duties and assignments. Such failure may result in short-term or permanent loss of access to County data/information or information systems and/or disciplinary action in accordance with Civil Service Rules, up to and including termination. For non County employees, including volunteers and employees of County contractors, misuse may result in a suspension or withdrawal of your access rights, termination of your participation in County programs, or appropriate action against the contractor under the contract's terms, or any combination of all or some of the above consequences.

Acknowledgement:

I have received and read the County of San Diego's Summary of Policies Regarding County Data/Information and Information Systems.

Print Name:

Signature:

Date Signed:

Supervisor / Manager / Witness:

Date Signed:

ALL SIGNERS:

COUNTY SIGNERS:

Keep a copy of this summary for your reference

Department Personnel Representative --- file the original of this form in the authorized user's agency or department personnel file.

NON-COUNTY SIGNERS: Contract administrator --- file the original form along with the contract

SAN DIEGO COUNTY MENTAL HEALTH SERVICES
ELECTRONIC SIGNATURE AGREEMENT

This Agreement governs the rights, duties, and responsibilities associated with the use of an electronic signature within the San Diego County Mental Health Services Management Information System.

The undersigned (I) understands that this Agreement describes my obligations to protect my electronic signature, and to notify appropriate authorities if it is compromised. I agree to the following terms and conditions:

I understand that my ability to electronically sign medical records is dependent upon utilization of a unique pass phrase that is assigned solely to me. I agree to keep my pass phrase I use to access my electronic signature secret and secure by taking reasonable security measures to prevent it from being compromised, and to prevent unauthorized disclosure of, access to, or use of it or of any media on which information about it is stored. I understand I may not share it with anyone under any circumstances. I agree that access to my electronic signature may be revoked or terminated per the terms of this agreement.

I will use my electronic signature and unique pass phrase to establish my identity and sign electronic documents and forms completed in the course of carrying out my assigned job duties. I am solely responsible for protecting my electronic signature and the pass phrase that allows me access to sign documents and forms electronically. If I suspect or discover that my electronic signature has been used by an unauthorized party, or otherwise compromised, then I will immediately notify the County Mental Health MIS Unit and request that my pass phrase be de-activated. I will then immediately request the ability to create a new pass phrase to use to access my electronic signature. I will immediately request that my electronic signature be revoked if I discover or suspect that it has been or is in danger of being subjected to unauthorized use in any way. I understand that I may also request revocation at any time for any other reason.

If I have requested that my access to my electronic signature be revoked, or I am notified that someone has requested that my access be suspended or revoked, and I suspect or discover that it has been or may be compromised or subjected to unauthorized use in any way, I will immediately cease using my pass phrase and my electronic signature. I will also immediately cease using my electronic signature upon termination of employment or termination of this Agreement.

I further agree that, for the purposes of authorizing and authenticating electronic health records, my electronic signature has the full force and effect of a signature affixed by hand to a paper document.

Requestor Signature _____ Date_____

Requestor Printed Name _____ Anasazi ID_____

Supervisor Signature _____ Date_____

Supervisor Printed Name _____

BEHAVIORAL HEALTH SERVICES
PROPERTY INVENTORY FORM

FISCAL YEAR: _____
COUNTY CONTRACT #: _____
PROGRAM NAME _____
PROGRAM SITE ADDRESS _____
COTR NAME: _____

DATE INVENTORY TAKEN: _____
month/date/year

NEW / RECONCILIATION / REVISION
(CIRCLE ONE whichever is applicable)

SIGNATURE: _____ NAME & JOB TITLE: _____

| Yellow County Property Tag/ Label Attached? (Yes/ No) | Description | Qty | Make | Model | Serial # | Acq. Date (Mo/Yr) | Original Cost/Fundi ng Source | Date of Disposal of Fixed Assets or Minor Equipment | Date AUD253 completed |
|--|-------------|-----|------|-------|----------|----------------------|-------------------------------------|---|--------------------------|
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REMARKS:



REASONS FOR RECOUPMENT
FOR FY 2011-2012

NON-HOSPITAL SERVICES

MEDICAL NECESSITY:

1. Documentation in the chart does not establish that the beneficiary has a diagnosis contained in California Code of Regulations, (CCR), title 9, chapter 11, section 1830.205(b)(1)(A-R).

CCR, title 9, chapter 11, section 1830.205(b)(1)(A-R); CCR, title 9, chapter 11, section 1810.345(a); CCR, title 9, chapter 11, section 1840.112(b)(1) and (4)

2. Documentation in the chart does not establish that, as a result of a mental disorder listed in CCR, title 9, chapter 11, section 1830.205(b)(1)(A-R), the beneficiary has, at least, one of the following impairments:

- A significant impairment in an important area of life functioning
- A probability of significant deterioration in an important area of life functioning
- A probability the child will not progress developmentally as individually appropriate
- For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate

CCR, title 9, chapter 11, section 1830.205(b)(2)(A – C); CCR, title 9, chapter 11, section 1830.210(a)(3)

3. Documentation in the chart does not establish that the focus of the proposed intervention is to address the condition identified in CCR, title 9, chapter 11, section 1830.205(b)(2)(A),(B),(C)-(see below):

- A significant impairment in an important area of life functioning
- A probability of significant deterioration in an important area of life functioning
- A probability the child will not progress developmentally as individually appropriate
- For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate

NOTE: EPSDT services may be directed toward the substance abuse disorders of EPSDT eligible children who meet the criteria for specialty mental health services under this agreement, if such treatment is consistent with the goals of the mental health treatment and services are not otherwise available.

CCR, title 9, chapter 11, section 1830.205(b)(3)(A); CCR, title 9, chapter 11, section 1840.112(b)(4)

REASONS FOR RECOUPMENT **FOR FY 2011-2012**

4. Documentation in the chart does not establish the expectation that the proposed intervention will do, at least, one of the following:
- Significantly diminish the impairment
 - Prevent significant deterioration in an important area of life functioning
 - Allow the child to progress developmentally as individually appropriate
 - For full-scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition

CCR, title 9, chapter 11, section 1830.205(b)(3)(B); CCR, title 9, chapter 11, section 1810.345(c)

CLIENT PLAN:

5. Initial client plan was not completed within time period specified in the MHP's documentation guidelines, or lacking MHP guidelines, within 60 days of intake unless there is documentation supporting the need for more time.

CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(5); MHP Contract, Exhibit A, Attachment 1, Appendix C

6. Client plan was not completed, at least, on an annual basis as specified in the MHP's documentation guidelines.

CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(5); MHP Contract, Exhibit A, Attachment 1, Appendix C

7. No documentation of client or legal guardian participation in the plan or written explanation of the client's refusal or unavailability to sign as required in the MHP Contract with the DMH.

CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(5); MHP Contract, Exhibit A, Attachment 1, Appendix C

8. For beneficiaries receiving Therapeutic Behavioral Services (TBS), no documentation of a plan for TBS.

CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(5); MHP Contract, Exhibit A, Attachment 1, Appendix C; DMH Letter No. 99-03, Pages 6-7

PROGRESS NOTES:

9. No progress note was found for service claimed.

CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(3); CCR, title 22, chapter 3, section 51458.1(a)(3); MHP Contract, Exhibit A, Attachment 1, Appendix C

10. The time claimed was greater than the time documented.

CCR, title 9, chapter 11, section 1810.440(c); CCR, title 22, chapter 3, section 51458.1(a)(3) and (4); CCR, title 22, chapter 3, section 51470(a); MHP Contract, Exhibit A, Attachment 1, Appendix C

REASONS FOR RECOUPMENT **FOR FY 2011-2012**

11. The progress note indicates that the service was provided while the beneficiary resided in a setting where the beneficiary was ineligible for Federal Financial Participation. (e.g. Institute for Mental Disease, jail, and other similar settings, or in a setting subject to lockouts per CCR, title 9, chapter 11.)

CCR, title 9, chapter 11, section 1840.312(g-h); CCR, title 9, chapter 11, sections 1840.360-1840.374; Code of Federal Regulations (CFR), title 42, sections 435.1008 – 435.1009; CFR, title 42, section 440.168; CCR, title 22, section 50273(a)(1-9); CCR, title 22, section 51458.1(a)(8); United States Code (USC), title 42, chapter 7, section 1396d

12. The progress note clearly indicates that the service was provided to a beneficiary in juvenile hall and when ineligible for Medi-Cal. (Dependent minor is Medi-Cal eligible. Delinquent minor is only Medi-Cal eligible after adjudication for release into community).

CFR, title 42, sections 435.1008 – 435.1009; CCR, title 22, section 50273(a)(1-9)

13. The progress note indicates that the service provided was solely for one of the following:

- a) Academic educational service
- b) Vocational service that has work or work training as its actual purpose
- c) Recreation
- d) Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors

CCR, title 9, chapter 11, section 1840.312(a-d); CCR, title 9, chapter 11, section 1810.247; CCR, title 22, chapter 3, section 51458.1(a)(5) and (7)

14. The claim for a group activity was not properly apportioned to all clients present.

CCR, title 9, chapter 11, section 1840.314(c); CCR, title 9, chapter 11, section 1840.316(b)(2)

15. The progress note does not contain the signature (or electronic equivalent) of the person providing the service.

MHP Contract, Exhibit A, Attachment 1, Appendix C

16. The progress note indicates the service provided was solely transportation.

CCR, title 9, chapter 11, section 1810.355(a)(2), CCR, title 9, chapter 11, section 1840.312(f); CCR, title 9, chapter 11, section 1810.247; CCR, title 9, chapter 11, section 1840.110(a)

17. The progress note indicates the service provided was solely clerical.

CCR, title 9, chapter 11, section 1840.312(f); CCR, title 9, chapter 11, section 1810.247; CCR, title 9, chapter 11, section 1840.110(a); CCR, title 9, chapter 11, section 1830.205(b)(3)

18. The progress note indicates the service provided was solely payee related.

CCR, title 9, chapter 11, sections 1840.312(f); CCR, title 9, chapter 11, section 1810.247; CCR, title 9, chapter 11, section 1840.110(a); CCR, title 9, chapter 11, section 1830.205(b)(3)

REASONS FOR RECOUPMENT **FOR FY 2011-2012**

19. No service provided: Missed appointment per DMH Letter No. 02-07

CCR, title 9, chapter 11, section 1840.112(b)(3); CCR, title 22, chapter 3, section 51470(a); DMH Letter No. 02-07

20. For beneficiaries receiving TBS, the TBS progress notes overall clearly indicate that TBS was provided solely for one of the following reasons:

- a) For the convenience of the family, caregivers, physician, or teacher
- b) To provide supervision or to ensure compliance with terms and conditions of probation
- c) To ensure the child's/youth's physical safety or the safety of others, e.g., suicide watch
- d) To address conditions that are not a part of the child's/youth's mental health condition

DMH Letter No. 99-03, Page 4

21. For beneficiaries receiving TBS, the progress note clearly indicates that TBS was provided to a beneficiary in a hospital mental health unit, psychiatric health facility, nursing facility, or crisis residential facility.

DMH Letter No. 99-03, Page 5

HOSPITAL SERVICES

MEDICAL NECESSITY:

22. Documentation in the chart does not establish that the beneficiary has a diagnosis contained in Section 1820.205(a)(1)(A-R).

CCR, title 9, chapter 11, section 1820.205(a)(1)(A-R)

23. Documentation in the chart does not establish that, as a result of a mental disorder listed in Section 1820.205(a)(1)(A-R), the beneficiary requires psychiatric inpatient hospital services for, at least, one of the following reasons:

- Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction
- Presence of symptoms or behaviors that prevent the beneficiary from providing for, or utilizing food, clothing or shelter
- Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health
- Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function
- Need for psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the beneficiary is in a psychiatric inpatient hospital
- Presence of either a serious adverse reaction to medications or the need for procedures/therapies that require continued psychiatric inpatient hospitalization

CCR, title 9, chapter 11, sections 1820.205(a)(2)(B) and 1820.205(b)

REASONS FOR RECOUPMENT
FOR FY 2011-2012

ADMINISTRATIVE DAY:

24. Documentation in the chart does not establish that the beneficiary previously met medical necessity for acute psychiatric inpatient hospital service during the current hospital stay.

CCR, title 9, chapter 11, sections 1820.220(j)(5) and 1820.225(d)(2)

25. Documentation in the chart does not establish that the hospital made the minimum number of contacts with the non-acute residential treatment facilities as evidenced by a lack of the following:

- a) The status of the placement option(s)
- b) The dates of the contacts, and
- c) The signature of the person making each contact.

CCR, title 9, chapter 11, sections 1820.220(j)(5) and 1820.225(d)(2)

CLIENT PLAN:

26. The beneficiary record does not contain a client plan.

CFR, title 42, section 456.180; CCR, title 9, chapter 11, section 1820.210

27. The client plan was not signed by a physician.

CFR, title 42, section 456.180; CCR, title 9, chapter 11, section 1820.210

| |
|--------------|
| OTHER |
|--------------|

28. A claim for a day when the beneficiary was not admitted to the hospital.

CCR, title 9, chapter 11, section 1840.320(b)(1)

FORMAL COMPLAINT BY PROVIDER

| | |
|-----------------|--|
| Provider's Name | |
| Program Manager | |
| Agency | |
| Address | |
| | |
| | |
| Phone | |
| Fax | |

[illegible]

MENTAL HEALTH PROFESSIONAL LICENSING WAIVER REQUEST

MH 12 (Rev 06/15/10)

(Please fill-in all boxes below. See reverse side for completion instructions.)

| | | | | | | |
|--|---|--|--|---|---|--|
| APPLICANT'S FULL NAME (Include aliases and maiden names): | | | | | | |
| TYPE OF WAIVER REQUEST (Please check appropriate box) | | | | | | |
| WITHIN CALIFORNIA/NOT LICENSE ELIGIBLE PSYCHOLOGIST CANDIDATE: (5 years maximum) <input type="checkbox"/> | OUT-OF-STATE/LICENSING-EXAM-READY: (3 years maximum) <table style="width: 100%; border: none;"> <tr> <td style="text-align: center; width: 33%;">PSYCHOLOGIST CANDIDATE <input type="checkbox"/></td> <td style="text-align: center; width: 33%;">LCSW CANDIDATE <input type="checkbox"/></td> <td style="text-align: center; width: 33%;">MFT CANDIDATE <input type="checkbox"/></td> </tr> </table> | | | PSYCHOLOGIST CANDIDATE <input type="checkbox"/> | LCSW CANDIDATE <input type="checkbox"/> | MFT CANDIDATE <input type="checkbox"/> |
| PSYCHOLOGIST CANDIDATE <input type="checkbox"/> | LCSW CANDIDATE <input type="checkbox"/> | MFT CANDIDATE <input type="checkbox"/> | | | | |
| DATE OF COMPLETION OF REQUIRED COURSEWORK: | EMPLOYMENT START DATE (in the position requiring the waiver): | | | | | |
| REQUEST SUBMITTED BY: (SIGNATURE----MENTAL HEALTH DIRECTOR/DESIGNEE) | | | | | | |
| PRINTED NAME: | | | | | | |
| DATE: | COUNTY: | | | | | |
| DO NOT COMPLETE THE FOLLOWING - FOR STATE DEPARTMENT OF MENTAL HEALTH USE ONLY | | | | | | |
| DATE COMPLETE WAIVER APPLICATION RECEIVED: | DATE WAIVER BEGINS: | | | | | |
| COMMENTS: | DATE WAIVER ENDS: | | | | | |
| Approved by: <input type="checkbox"/> Program Administrator, Program Compliance OR <input type="checkbox"/> Chief, Medi-Cal Oversight | | | | | | |
| Signature: | | Date: | | | | |
| This waiver is granted pursuant to Welfare and Institutions Code Section 5751.2 and with the stipulation that the employer and the applicant assume responsibility for meeting all applicable statutory and regulatory requirements during the approved waiver period. | | | | | | |

MENTAL HEALTH PROFESSIONAL LICENSING WAIVER REQUEST

MH 12 (Rev 06/15/10)

PROFESSIONAL LICENSING WAIVER REQUEST**Instructions for Completing This Form**

- 1) Applicant's Full Name, Include Aliases and Maiden Names: DMH staff need this information, when applicable, to track accurately the applicant's waiver history.
- 2) Type of Waiver Request: Clearly indicate the type of waiver request. To be eligible for the Out-of-State/License-Ready category, an applicant must be both license-ready and recruited from out-of-State. When submitting an application for an Out-of-State/License-Ready waiver, the MHP must submit a letter from the appropriate licensing board which states that the applicant has sufficient experience to gain admission to the licensing examination.
- 3) Employment Start Date (In the Position Requiring the Waiver): Specify the date the applicant will start employment in the position requiring a waiver.

In order for the DMH to determine if the applicant has been previously employed in a position requiring a waiver, **it is necessary to attach a copy of the applicant's post-degree employment history.** This can take the form of a current, complete resume or recent employment application.

- 4) Request Submitted By (Mental Health Director/Designee): All waiver requests must be submitted, signed and dated by the local county mental health director or the director's designee.

For additional information on the professional licensing waiver process, see DMH Letter No 10-03. .

This procedure applies only to providers approved for MAA Claiming.

Medi-Cal Administrative Activities (MAA) Procedures

MAA activities in mental health are governed by a set of procedures. These procedures are described in detail in the MAA Instruction Manual developed by the State Department of Mental Health, and are summarized below.

The Claiming Plan

In order to participate in MAA, the County must submit a Claiming Plan to the State for approval by the last day of the quarter in which the first invoice will be submitted. Using a standardized format developed cooperatively by the State and Federal Medicaid agencies, the MAA Claiming Plan must describe in detail each of the MAA activities for which claims will be submitted, by job class. The standardized format can be found in the California Department of Mental Health MAA instruction manual.

The Claiming Plan also describes the units that will be participating in MAA, the type of supporting documentation that will be maintained, and the development and documentation of costs relating to MAA. It indicates which activities will be focused entirely on the Medi-Cal population. If the activities will be focused on a larger population, the Claiming Plan must describe the methodology that will be used to discount the claim by the percentage of Medi-Cal eligibles in the population.

The State Department of Mental Health has established procedures for amending the MAA Claiming Plan. It has also developed a Claiming Plan checklist and a checklist to use when submitting amendments to the Claiming Plan. Copies of these documents, along with a copy of the most recently approved version of the plan, are on file in the Mental Health Plan administrative offices. Claiming plans and any amendments will remain in effect from year to year. A Claiming Plan will not need to be amended, unless the scope of MAA is significantly changed or a new type of activity is undertaken. For example, a Claiming Plan must be amended when a new outreach campaign or program is instituted, or a new claiming unit performing MAA is created.

Claiming Procedures

Claims for MAA reimbursement are submitted quarterly to the State Department of Mental Health (DMH) by HHSA. A detailed quarterly invoice is prepared for each mental health unit participating in MAA, as identified in the claiming plan. County-operated programs are one unit; each participating contractor is a separate unit. A summary invoice is also prepared that aggregates all invoices submitted by mental health. An approved claiming plan covering the period of the claim must be in place before an invoice may be paid.

The County is required to provide DMH with complete invoice and expenditure information no later than December 31, following the fiscal year for which a claim is submitted. Invoice and expenditure information must be submitted to DMH prior to or with the County's cost report for the current fiscal year. DMH may approve the claim, return it for correction and/or revision, or deny the claim. The County may request reconsideration of a denied claim in writing within 30 days of receiving the denial.

The detailed quarterly invoice captures the time spent on MAA, the Medi-Cal percentage, expenditure and revenue information on a single spreadsheet.

MAA Training

All staff participating in MAA, and completing MAA activity logs, will attend MAA training sessions on at least an annual basis. Sign-in sheets will serve as a record of the individual's attendance. Training will be scheduled and provided at the direction of Mental Health Administration.

Reporting MAA Activities

MAA activities are recorded in MH MIS.. The reporting requirements are somewhat different than what is required for direct services. For MAA, staff must report the following each time an MAA activity is performed:

- the day the activity occurred;
- the activity code (as a proxy for the name of the activity);
- the number of minutes spent on the activity;
- the name of the employee performing the activity.

A standardized MAA Activity Log or Service Log has been developed; however, programs can develop their own as long as it contains the essential MAA reporting information. When programs develop their own form, they should forward it to the MAA Coordinator to ensure it covers the basic elements. Each activity log is to be signed by the employee before he/she gives it to the clerical staff responsible for entering data into Mental Health MIS. Activity logs may cover multiple days. Completed logs should be turned in to the person responsible for entering the information into MH MIS on a timely basis, but no later than the fifth working day after the end of each month.

Document Retention

The County of San Diego has adopted a record retention policy that requires these records to be retained for ten (10) years. Program managers are responsible for storing signed, original versions of all MAA activity logs, outreach materials, and all documentation that supports the MAA claimed by their staff.

Becoming an MH MIS User

An MH MIS account is needed to enter MAA into Anasazi. This information can be found in the Anasazi User Manual Page 10 on the Optum Health public sector site: <http://www.optumhealthsandiego.com/>

Quality Assurance; Monitoring

The quality of the MAA program will be monitored through quarterly reports from MH MIS.. The Mental Health Services MAA Coordinator will disseminate these reports to program managers, notifying them of any identifiable discrepancies found. These reports will provide managers with summaries of the amount of time reported to all MAA activities, by staff name. Program managers are expected to use the monitoring reports to:

- ensure that staff is reporting their MAA time accurately, using the correct activity codes;
- ensure that all staff that should be reporting MAA is doing so;
- ensure that MAA time is being reported consistently among staff in same classification.

Managers are required to ensure that corrective action is taken on any discrepancies they find or that have been identified by the MAA coordinator. Random reviews will take place to ensure that staff is reporting MAA correctly.

The MAA Audit File

An MAA audit file will be maintained at Mental Health Administration, and includes the following:

- a copy of the most recently approved MAA claiming plan for the County and for each participating contract agency;
- copies of current SPMP forms, and verification that each SPMP's license, where applicable, is current;
- job descriptions and/or duty statements for all staff participating in MAA;
- electronic or hard copies of the raw data used to calculate each quarterly percentage of MAA activity;
- electronic or hard copies of the reports used to establish the Medi-Cal percentage for each quarterly MAA claim;
- locations (with addresses) where MAA activity logs are kept on file, and where copies of information used in outreach or eligibility assistance activities are kept;
- copies of annual training schedules, training rosters, and materials used in training.

Who Can Claim MAA: An Overview

Clinical staff

- MAA may be used for client-based activities that are not part of a direct service or that are provided to an individual who does not have an open case anywhere within the system. MAA also includes outreach activities to inform individuals or groups about the availability of Medi-Cal and mental health services.

Administrators

- MAA includes program planning and contract administration.
- MAA includes outreach activities to inform individuals or groups about the availability of mental health services.

Clerical staff, Human Service Specialist and all other staff

- MAA includes activities that assist individuals, regardless of their case status, to apply for Medi-Cal or to access services covered by Medi-Cal.
- MAA activities include the administrative support clerical staff provide around outreach, contract administration, program planning, and crisis situations.

The MAA Activity Codes

A set of MAA activity codes has been developed for local mental health programs. The activities include:

Activity Code

| | |
|-----|--|
| 204 | Medi-Cal Outreach |
| 205 | Mental Health Outreach |
| 203 | Facilitating Medi-Cal Eligibility Determinations |
| 201 | Case Management of Non-Open Cases |
| 202 | Referral in Crisis Situations – Non-Open Cases |
| 209 | MAA Coordination and Claims Administration |

MAA Activity Code Definitions

204 Medi-Cal Outreach – This code may be used by all staff in county and contract programs. Includes the following:

- informing Medi-Cal eligibles or potential Medi-Cal eligibles about Medi-Cal services, including Short-Doyle/Medi-Cal services;

- assisting at-risk Medi-Cal eligibles or potential Medi-Cal eligibles to understand the need for mental health services covered by Medi-Cal;
- actively encouraging reluctant and difficult Medi-Cal eligibles and potential Medi-Cal eligibles to accept needed health or mental health services;
- performing information and referral activity that involves referring Medi-Cal beneficiaries;
- referring Medi-Cal eligibles to Medi-Cal eligibility workers.

205

457

Mental Health Outreach – This code may be used by all staff in county and contract programs. Includes the following:

- informing at-risk populations about the need for and availability of Medi-Cal and non-Medi-Cal mental health services;
- providing telephone, walk-in or drop-in services for referring persons to Medi-Cal and non-Medi-Cal mental health programs.

203

Facilitating Medi-Cal Eligibility Determinations – This code may be used by all staff in county and contract programs. Includes the following:

- screening and assisting applicants for mental health services with the application for Medi-Cal benefits.

201

Case Management of Non-Open Cases – May be used by all staff in county and contract agencies. Includes the following:

- gathering information about an individual's health and mental health needs.
- assisting individuals to access Medi-Cal covered physical health and mental health services by providing referrals, follow-up and arranging transportation to health care.

202Referral in Crisis Situations - Non-Open Cases – May be used by all staff in county and contract programs. Includes the following:

- intervening in a crisis situation by referring to mental health services.

209

MAA Coordination and Claims Administration – This code may be used by all staff in county and contract programs. Includes the following:

- MAA Training

**San Diego County Mental Health Services
MAA/Community Outreach Service Record**

| | | |
|---------|--|-----------|
| Form #: | Client: Generic, Client | Case #: 1 |
| Unit: | <input checked="" type="checkbox"/> Single Contact | |

| | | | |
|-----------------|---------|--------------|--------------|
| Date of Service | SubUnit | Service Code | Service Time |
| Date of Service | SubUnit | Service Code | Service Time |
| Date of Service | SubUnit | Service Code | Service Time |
| Date of Service | SubUnit | Service Code | Service Time |
| Date of Service | SubUnit | Service Code | Service Time |
| Date of Service | SubUnit | Service Code | Service Time |

I certify that the service(s) shown on this sheet were provided by me personally.

| | | | |
|-------------------|------------------|-----------|------|
| Print Server Name | Server Signature | Server ID | Date |
|-------------------|------------------|-----------|------|

| Community Outreach – Mental Health Services Act | |
|---|--|
| 5 Screening (Non-MAA) | 65 Community Services (Non-MAA) |
| MAA Codes | |
| 201 MAA Case Mgmt/Non Open Non-SPMP | 205 MAA Mental Health Outreach |
| 202 MAA Crisis Referral/Non-Open | 206 MAA SPMP Case Mgmt/Non-Open (County Only) |
| 203 MAA Medi-Cal Eligibility Intake | 207 MAA Program Planning & Development SPMP (County Only) |
| 204 MAA Medi-Cal Outreach | 208 MAA Program Planning & Development Non-SPMP |
| | 209 MAA Implementation / Training |

REV: 09.30.2008

Attachment-A, Refer to #01-01-221

Appendix P Mental Health Services Act

QUARTERLY PROGRESS MENTAL HEALTH IEP REPORT

Program: _____

Address: _____

Telephone: _____

| | |
|-----------------------------|-------------|
| Patient Name: | DOB: |
| Therapist: | |
| Reporting Period: to | |

Progress Rating: 1-Goal not met; symptoms stayed the same or got worse
2-Goal not met completely, but some progress made (1-50% of goal achieved)
3-Goal not met completely, but substantial progress made (51-99% of goal achieved)
4-Goal met or exceeded (100% of goal achieved)

GOAL # 1:

Progress: 1 ☐ 2 ☐ 3 ☐ 4 ☐

Comments on goal/progress:

GOAL # 2:

Progress: 1 ☐ 2 ☐ 3 ☐ 4 ☐

Comments on goal/progress:

GOAL # 3:

Progress: 1 ☐ 2 ☐ 3 ☐ 4 ☐

Comments on goal/progress:

Scheduled Frequency of Sessions: **Weekly** ☐ **Bi-Weekly** ☐ **Monthly** ☐

Concerns with Attendance: No ☐ Yes ☐

Date of Contacts with School:

Therapist Signature

Date

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY
SAN DIEGO MENTAL HEALTH SERVICES
MENTAL HEALTH TREATMENT PLAN

Date: _____ **Student:** _____ **Type of Service:** _____ **Start Date: ASAP** **Duration: 6 months**

Area of Need:

Present Level

Measurable Long-Term Goal:

| | | | |
|--|--|---|---|
| Parents will be informed of progress <input checked="" type="checkbox"/> Quarterly <input type="checkbox"/> Trimester <input type="checkbox"/> Semester <input type="checkbox"/> Other: _____ How ? <input type="checkbox"/> Annotated Goals/Objectives <input checked="" type="checkbox"/> Other: teacher, therapist | Periodic Review Dates 1. _____ 2. _____ 3. _____ 4. _____ | Progress Toward Goal 1. _____ 2. _____ 3. _____ 4. _____ | Sufficient Progress to Meet Goal <input type="checkbox"/> Yes <input type="checkbox"/> No _____ <input type="checkbox"/> Yes <input type="checkbox"/> No _____ <input type="checkbox"/> Yes <input type="checkbox"/> No _____ <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
|--|--|---|---|

Benchmark/Short-Term Objective: Within 2 months:
1. _____

Date:
☐ Achieved
☐ Reviewed

Person(s) Responsible: client, therapist

Benchmark/Short-Term Objective: Within 4 months:
1. _____

Date:
☐ Achieved
☐ Reviewed

Person(s) Responsible: client, therapist

Area of Need

Present Level:

Measurable Long-Term Goal:

| | | | |
|--|--|---|---|
| Parents will be informed of progress <input checked="" type="checkbox"/> Quarterly <input type="checkbox"/> Trimester <input type="checkbox"/> Semester <input type="checkbox"/> Other: _____ How ? <input type="checkbox"/> Annotated Goals/Objectives <input checked="" type="checkbox"/> Other: teacher, therapist | Periodic Review Dates 1. _____ 2. _____ 3. _____ 4. _____ | Progress Toward Goal 1. _____ 2. _____ 3. _____ 4. _____ | Sufficient Progress to Meet Goal <input type="checkbox"/> Yes <input type="checkbox"/> No _____ <input type="checkbox"/> Yes <input type="checkbox"/> No _____ <input type="checkbox"/> Yes <input type="checkbox"/> No _____ <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
|--|--|---|---|

Benchmark/Short-Term Objective: Within 2 months:

Date:
☐ Achieved
☐ Reviewed

Person(s) Responsible: client, therapist

Benchmark/Short-Term Objective: Within 4 months:

Date:
☐ Achieved
☐ Reviewed

Person(s) Responsible: client, therapist

Student Signature

Date

Signature of Parent

Date

Signature of Mental Health Service Representative

Date

A.Q.2

**COUNTY OF SAN DIEGO
DEPARTMENT OF HEALTH SERVICES
MENTAL HEALTH SERVICES**

NEED FOR IEP REVIEW

TO: _____ DATE: _____

FROM: _____ TELEPHONE _____

RE: _____ DOB: _____

A. We are unable to continue our delivery of mental health assessment services to your pupil _____, for the following reason:

_____1. Parent has not signed a mental health assessment plan.

_____2. Parent has failed to come in for scheduled assessment visits.

_____3. Parent has withdrawn permission for the mental health assessment.

_____4. Other/comments _____

B. This is to notify you of a substantial change to the IEP/Treatment Plan because:

_____1. Client has completed treatment.

_____2. Client is in need of change in mental health services level of care.

_____3. Child is not benefiting from his mental health services.

_____4. Parent no longer wishes to have treatment services identified on the IEP for the child through Short-Doyle/MHS.

_____5. Parent has had difficulty following through with the treatment plan.

_____6. Parent has moved to another district/SELPA

Other/comments _____

Organizational Provider Operations Handbook

Appendix R **Payment Schedule** **Budget Guidelines for Cost** **Reimbursement Contract** **Only (*Contractor*)**

